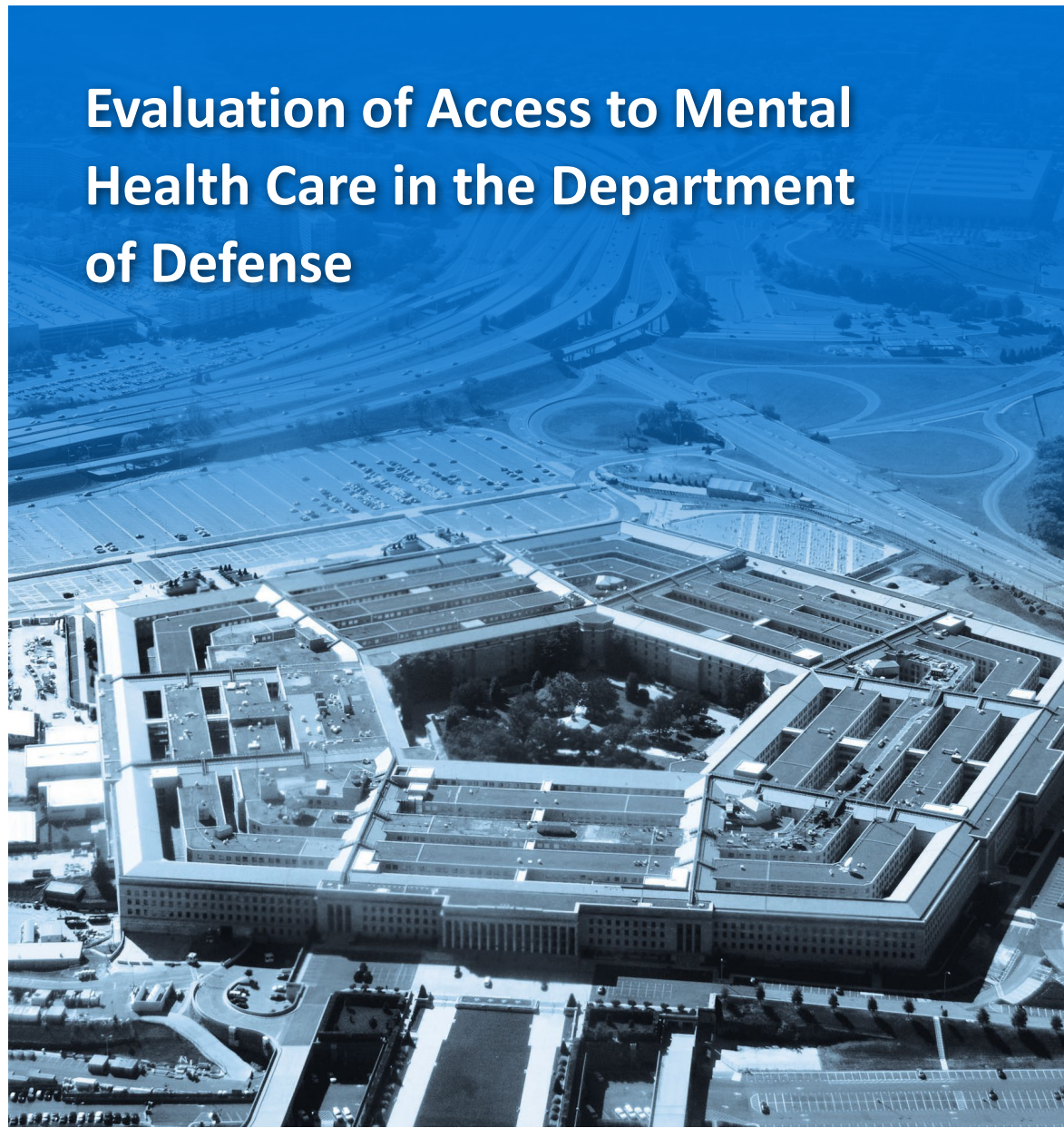




# INSPECTOR GENERAL

*U.S. Department of Defense*

AUGUST 10, 2020



## Evaluation of Access to Mental Health Care in the Department of Defense

INTEGRITY ★ INDEPENDENCE ★ EXCELLENCE







# Results in Brief

## *Evaluation of Access to Mental Health Care in the Department of Defense*

August 10, 2020

### Objective

The objective of this evaluation was to determine whether the DoD meets outpatient mental health access to care standards for active duty service members and their families, in accordance with law and applicable DoD policies.

### Background

Military service, especially combat, can carry a psychological cost for the DoD military members and their families who support them. The DoD has the responsibility to effectively identify and treat mental health conditions through a consistent standard of care. The DoD Military Health System (MHS) is one of the largest integrated health care systems in the United States. Integrated health care is offered to active duty service members and their families through military medical treatment facilities (MTFs), known as the direct care system, and through networks of civilian providers operated by civilian managed care support contractors, known as the purchased care system.<sup>1</sup> Active duty service members and their families enrolled to an MTF use the purchased care system if the MTF does not have an available appointment due to lack of capability or capacity.<sup>2</sup>

Federal Regulations establish access to care standards that apply to both the direct and purchased care systems and establish

<sup>1</sup> "Purchased care" as used in the report is defined as "private sector care" by the Defense Health Agency.

<sup>2</sup> Active duty service members require a preauthorization before receiving mental health services in the purchased care system.

### Background (cont'd)

that the wait time for an urgent care visit must generally not exceed 24 hours, a routine visit must not exceed 1 week (7 days), and a specialty care referral must not exceed 4 weeks (28 days).

### Finding

The DoD did not consistently meet outpatient mental health access to care standards for active duty service members and their families, in accordance with law and applicable DoD policies. Specifically, for the December 2018 to June 2019 time period, we found that:

- 7 of 13 MTFs (direct care system) or their supporting TRICARE network (purchased care system) did not meet the specialty mental health access to care standard each month; and
- An average of 53 percent (4,415 of 8,328 per month) of all active duty service members and their families, identified as needing mental health care and referred to the purchased care system, did not receive care and the MHS did not know why.

Additionally, during our site visits between August and October 2019, 9 of 13 MTFs reported the inability to meet evidence-based treatment (treatment proven successful in controlled studies) or monitor the prescribed behavioral health treatment dosage (including visit frequency) in accordance with DHA-PI 6490.02, which means the patient's follow-up treatment may have been delayed or did not occur.

The DoD did not consistently meet outpatient mental health access to care standards because the DHA:

- lacked an MHS-wide model to identify appropriate levels of staffing in direct and purchased care;
- published inconsistent and unclear access to mental health care policies;
- did not have visibility of patients who attempted, but were unable, to obtain mental health appointments in the purchased care system; and



# Results in Brief

## *Evaluation of Access to Mental Health Care in the Department of Defense*

### **Finding (cont'd)**

- measured the 28-day specialty access to care standard differently between the direct and purchased care systems, both of which included only those patients who were able to get an appointment, excluded patients who self-referred, and considered only the patients' first appointment.

As a result, thousands of active duty service members and their families may have experienced delays in obtaining mental health care. The delays may have involved numerous members not being able to: (1) see the right provider at the right time, (2) obtain mental health care at all, or (3) receive timely follow-up treatment. All of these types of delays in mental health care increase the risk of jeopardizing patient safety and affecting the readiness of the force. For example, in June 2019, active duty service members and their families referred to the TRICARE network waited 57 days for behavioral health counseling and therapy intake, and 79 days for psychiatry, on average, at Naval Health Clinic Oak Harbor.

### **Recommendations**

We made a total of 14 recommendations to the Assistant Secretary of Defense for Health Affairs (ASD[HA]) and the Defense Health Agency (DHA) Director to improve access to mental health care in the DoD. We recommended the ASD(HA) update the ASD(HA) Memorandum, "TRICARE Policy for Access to Care", February 23, 2011, to remove the eight-visit limitation for outpatient mental health care.

We also made recommendations for the DHA Director to develop a single MHS-wide model to identify appropriate staffing levels, update and clarify DoD and DHA policies, develop a method to book patient appointments in the purchased care system, and develop standardized mental health access to care measures.

### **Management Comments**

The Defense Health Agency (DHA) Director, responding for the Assistant Secretary of Defense for Health Affairs (ASD[HA]), agreed to update the ASD(HA) Memorandum, "TRICARE Policy for Access to Care", February 23, 2011, to remove the eight-visit limitation for outpatient mental health care. The DHA Director also responded to the recommendations directed towards DHA. The DHA Director agreed with 9, partially agreed with 3, and disagreed with 1, of the 13 subordinate recommendations for the DHA.

The DHA Director stated that although the DHA is adopting a consistent approach to determine which beneficiaries receive mental health care at an MTF, mental health care will vary by MTF mission and capabilities. The DHA Director further stated that the 7-day access standard will be applied to mental health providers in primary care clinics; however, the 28-day access standard, which applies to all specialty care, will continue to be applied to mental health specialty care clinics in both direct and private sector care. The DHA Director also stated that a standard process will be established for mental health appointments, but the elements of the mental health assessment will be tailored to each beneficiary's needs.

The DHA Director disagreed with the recommendation to develop standardized mental health access to care measures for direct and purchased care for both active duty service members and their families, including tracking the reasons referrals are not used. The DHA Director stated that this recommendation would require invasive questioning of beneficiaries, which could increase stigma and reluctance to seek needed care.



# Results in Brief

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## *Evaluation of Access to Mental Health Care in the Department of Defense*

### **Our Response**

Based on the responses from the DHA Director, we consider seven recommendations resolved, but open, and seven unresolved.

Seven recommendations are unresolved because we either disagreed with the DHA Director's response or the response did not fully address the recommendation. We also modified three recommendations to be more specific based on management comments received.

## Recommendations Table

Management	Recommendations Unresolved	Recommendations Resolved	Recommendations Closed
Assistant Secretary of Defense (Health Affairs)	None	1	None
Director, Defense Health Agency	2.a, 2.c.1, 2.c.2, 2.c.5, 2.f.1, 2.f.2, 2.f.4	2.b, 2.c.3, 2.c.4, 2.d, 2.e, 2.f.3	None

Please provide Management Comments by September 9, 2020.

**Note:** The following categories are used to describe agency management’s comments to individual recommendations.

- **Unresolved** – Management has not agreed to implement the recommendation or has not proposed actions that will address the recommendation.
- **Resolved** – Management agreed to implement the recommendation or has proposed actions that will address the underlying finding that generated the recommendation.
- **Closed** – OIG verified that the agreed upon corrective actions were implemented.



**INSPECTOR GENERAL  
DEPARTMENT OF DEFENSE  
4800 MARK CENTER DRIVE  
ALEXANDRIA, VIRGINIA 22350-1500**

August 10, 2020

**MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS  
DIRECTOR, DEFENSE HEALTH AGENCY**

**SUBJECT: Evaluation of Access to Mental Health Care in the Department of Defense,  
(Report No. DODIG-2020-112)**

This final report provides the results of the DoD Office of Inspector General's evaluation. We previously provided copies of the draft report and requested written comments on the recommendations. We considered management's comments on the draft report when preparing the final report. These comments are included in the report.

The Defense Health Agency (DHA) Director, responding for the Assistant Secretary of Defense (Health Affairs) [ASD(HA),] agreed to address Recommendation 1; therefore, Recommendation 1 is considered resolved and open. We will close this recommendation when we receive an electronic copy of the DHA Procedural Instruction that will replace the ASD(HA) Policy Memorandum, "TRICARE Policy for Access to Care," dated February 23, 2011.

The DHA Director also provided comments to the 13 subordinate recommendations within Recommendation 2. We consider Recommendations 2.b, 2.c.3, 2.c.4, 2.d, 2.e, and 2.f.3 resolved and open. As described in the Recommendations, Management Comments, and Our Response section of this report, the recommendations may be closed when we receive adequate documentation showing that all agreed-upon actions to implement the recommendations have been completed. Therefore, please provide us within 90 days your response concerning specific actions in process or completed on the recommendations. Your response should be sent to [REDACTED]

This report also contains seven subordinate recommendations within Recommendation 2 that are considered unresolved because the DHA Director either did not fully address the recommendation or contradicted existing policy in response to the recommendation, or we disagreed with the DHA Director's comments. We also modified recommendations 2.a, 2.c.5, and 2.f.4 to be more specific and clarify the intent. Therefore, as discussed in the Recommendations, Management Comments, and Our Response section of this report, these seven subordinate recommendations remain unresolved and open. We will track these recommendations until an agreement is reached on the actions to be taken to address the recommendations, and adequate documentation has been submitted showing that the agreed-upon action has been completed.

DoD Instruction 7650.03 requires that recommendations be resolved promptly. Therefore, please provide us within 30 days (September 9th, 2020) your response concerning specific actions in process or alternative corrective actions proposed on the unresolved recommendations.

Your response should be sent to either [REDACTED]

We appreciate the cooperation and assistance received during this evaluation.



Carolyn Ramona Hantz  
Assistant Inspector General for Evaluations  
Programs, Combatant Commands, and  
Overseas Contingency Operations



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# Introduction

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## Objective

The objective of this evaluation was to determine whether the DoD met outpatient mental health access to care standards for active duty service members and their families, in accordance with law and applicable DoD policies.<sup>3</sup> Specifically, we evaluated:

- direct care appointment booking and referral processes and measures for outpatient mental health appointments with a specialty provider;
- purchased care appointment booking and measures for outpatient mental health specialty providers; and
- how the military health system determines the required capacity to meet patient demand for outpatient mental health services.<sup>4</sup>

## Background

According to the World Health Organization, mental health is “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.”<sup>5</sup> Conversely, mental health disorders are health conditions involving significant changes in thinking, emotion, and behavior and are associated with distress and problems functioning in social, work, or family activities. Common types of mental health disorders include anxiety, depression, and post-traumatic stress disorder (PTSD).

In 2017, there were an estimated 46.6 million adults aged 18 or older in the United States with a mental illness. This number represents 18.9 percent of all U.S. adults. In the same year, the prevalence of diagnosed mental health disorders among active duty service members was almost 14 percent, or about 203,040 active duty service members.<sup>6</sup> An untreated mental health disorder could significantly affect duty performance and could preclude an active duty service member from deploying.<sup>7</sup> Military service, especially combat, may carry a psychological cost

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<sup>3</sup> The three Services and the Defense Health Agency use the terms Mental Health, Behavioral Health, and Psychological Health interchangeably. In this report, the term mental health is used. However, if a policy uses “behavioral health” or “psychological health” we use that policy’s language. “Purchased care” as used in the report is defined as “private sector care” by the Defense Health Agency.

<sup>4</sup> For this evaluation, capacity is defined as the number of outpatient mental health appointments available. If demand for outpatient mental health care is greater than the capacity, then there will be a delay in providing care.

<sup>5</sup> World Health Organization. Promoting Mental Health: Concepts, Emerging Evidence, Practice (Summary Report) Geneva: World Health Organization; 2004.

<sup>6</sup> Psychological Health Center of Excellence, <https://pdhealth.mil/research-analytics/psychological-health-numbers/mental-health-disorder-prevalence-and-incidence>.

<sup>7</sup> DoD Instruction 6490.07, Deployment Limiting Conditions, February 5, 2010.

for DoD military members and the families who support them. The DoD has the responsibility to effectively identify and treat all mental health conditions through a consistent standard of care.<sup>8</sup>

### ***Military Health System***

The Military Health System (MHS) is one of the largest integrated health care systems in the United States. Integrated health care is offered to active duty service members and their families through military medical treatment facilities (MTFs), known as the direct care system, and through networks of civilian providers operated by civilian managed care support contractors, known as the purchased care system.<sup>9</sup> The purchased care system in the United States has two TRICARE managed care support contractors, the East and West regions.<sup>10</sup> Active duty service members and their families enrolled to an MTF use the purchased care system if the MTF does not have an available appointment, which could occur because all the available appointments were filled or the specialty needed was not available at the MTF.<sup>11</sup>

According to the MHS website, the DoD is transforming the MHS to improve the readiness of the force and the health care provided to warfighters and their families.<sup>12</sup> These efforts include the following organizational, infrastructure, and manpower changes.

- Beginning October 1, 2018, all MTFs within the MHS, whether under Service command or Defense Health Agency (DHA) administration and management, adhere to the same DHA-established policies, procedures, and standard clinical and business processes. The DHA assumed administration and management responsibilities from the Army, Navy, and Air Force for all military hospitals and clinics on October 1, 2019, at the direction of the FY 2017 National Defense Authorization Act (NDAA).<sup>13</sup>

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<sup>8</sup> Report to Congress on the Department of Defense Plan to Achieve the Vision of the DoD Task Force on Mental Health, September 2007.

<sup>9</sup> Defense Health Agency Procedures Manual Number 6025.13, Volume 1, "Clinical Quality Management in the Military Health System, Volume 1: General Clinical Quality Management," August 29, 2019, defines the direct care system and purchased care system. The direct care system is comprised of healthcare facilities and medical support organizations managed by the DoD through the Defense Health Agency (DHA) or Service Surgeons General in accordance with applicable federal laws and regulations. The purchased care system is a component of the uniform program of medical and dental care for members and certain former members of the Services, and for their dependents where services are provided to beneficiaries by TRICARE-authorized civilian network and non-network healthcare providers and facilities.

<sup>10</sup> TRICARE is the worldwide DoD health care program. The purchased care system in the U.S. also includes the U.S. Family Health Plan and TRICARE for Life, which were not the focus of this evaluation.

<sup>11</sup> Active duty service members require a preauthorization before receiving mental health services in the purchased care system.

<sup>12</sup> <https://health.mil/Military-Health-Topics/MHS-Transformation>.

<sup>13</sup> The DHA is a joint, integrated Combat Support Agency that enables the Army, Navy, and Air Force medical services to provide a medically ready force and ready medical force to Combatant Commands in both peacetime and wartime. The DHA supports the delivery of integrated, affordable, and high quality health services to MHS beneficiaries and is responsible for driving greater integration of clinical and business processes across the MHS.



For MTFs in the United States, DHA currently executes administration and management through interim support agreements with the Services. (Organization)

- Congress, in the same NDAA, directed the DoD to assess the existing infrastructure of the MHS, which may result in reducing or expanding capabilities at some MTFs. (Infrastructure)
- The DoD's FY 2020 budget proposal recommended the realignment of approximately 17,000 military personnel from the MHS into operational forces. The DHA reported on the MHS website that it was formulating plans to ensure that beneficiaries continue to have uninterrupted access to high quality care during these changes by hiring new civilian and contract personnel at the MTFs and ensuring appropriate access to the TRICARE network providers. (Manpower)

Another organizational reform effort is the development of the new electronic health record, MHS GENESIS, which provides enhanced, secure technology to manage patient health information. According to the MHS website, when fully deployed, MHS GENESIS will provide a single health record for service members, veterans, and their families.

### ***Access to Care Standards***

Access to health services is "the timely use of personal health services to achieve the best health outcomes."<sup>14</sup> Federal regulations establish access to care standards that apply to both the direct and purchased care systems and establish that the wait time for an urgent care visit must generally not exceed 24 hours, a routine visit must not exceed 1 week (7 days), and a specialty care referral must not exceed 4 weeks (28 days).<sup>15</sup>

Public Law 109-163 – NDAA FY 2006, Section 723, directed the Secretary of Defense to "establish within the Department of Defense a task force to examine matters relating to mental health and the Armed Forces." The task force report contained 95 recommendations for improvement in the psychological health of members of the Armed Forces and their families. One of the recommendations stated that the "DoD should revise TRICARE access standards to equate access to basic mental health services with access for basic primary medical care – seven days or fewer (depending on the severity of the presenting concern)."

<sup>14</sup> Institute of Medicine, Committee on Monitoring Access to Personal Health Care Services. *Access to Health Care in America*. Millman M, editor. Washington, D.C.: National Academies Press. 1993.

<sup>15</sup> Title 32 Code of Federal Regulations section 199.17 (p)(5)(2019). A referral is a written order from a primary care physician or other provider for a patient to see a specialist.

In 2007, the Under Secretary of Defense for Personnel and Readiness stated in a Report to Congress, “To facilitate access, we are clarifying policy for both our MTFs and for our TRICARE network providers that limits wait time for initial mental health visits to seven days.”<sup>16</sup> In 2011, the Assistant Secretary of Defense for Health Affairs published clarifying guidance for access to care standards, including behavioral health needs. The access to care standard to perform a non-urgent initial behavioral health assessment is considered routine care (7 days) if the patient seeks treatment within primary care or self-refers to a specialty mental health clinic.<sup>17</sup> However, according to 32 CFR sec. 199.17 (2019), the access to care standard for a specialty mental health referral must not exceed 4 weeks (28 days). In addition, Section 722 of the FY 2020 NDAA states, “If the Secretary of Defense is unable to provide mental health services in a military medical treatment facility to a member of the Armed Forces within 15 days of the date on which such services are first requested by the member, the Secretary may refer the member to a provider under the TRICARE program.”

The DHA published Interim Procedures Memorandum 18-001 on July 3, 2018, and reissued the interim memorandum on July 12, 2019, and February 4, 2020.<sup>18</sup> The interim memorandum establishes DHA procedures that describe standard appointment booking processes, procedures, and appointment types in primary, specialty, and behavioral healthcare in Defense Health Program-funded DoD MTFs. The interim memorandum also “establish[es] uniform accountability and... standard processes and procedures in all MTFs to improve medical readiness, reduce unwarranted variation, enhance the patient experience, increase access to care, minimize fragmentation, and support the principles of a highly reliable organization.” DHA IPM 18-001 describes behavioral health care specific processes and procedures and states:

SPEC [specialty] appointments are for the patient’s first non-urgent specialty appointment in behavioral health. The MTF will ensure at least a minimum of three appointments each duty day are available within 28 days.

ROUT [routine] appointments may be used for self-referred, non-urgent behavioral health care needs...The MTF will ensure at least three ROUT appointments each duty day are available within 7 days.

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<sup>16</sup> Report to Congress on the Department of Defense Plan to Achieve the Vision of the DoD Task Force on Mental Health, September 2007.

<sup>17</sup> Health Affairs Policy 11-005 TRICARE Policy for Access to Care, February 23, 2011, and Defense Health Agency-Interim Procedures Memorandum (DHA IPM) 18-001, “Standard Appointing Processes, Procedures, Hours of Operation, Productivity, Performance Measures and Appointment Types in Primary, Specialty, and Behavioral Health Care in Medical Treatment Facilities (MTFs),” February 4, 2020.

<sup>18</sup> Defense Health Agency Interim Procedures Memorandum 18-001, “Standard Appointing Processes, Procedures, Hours of Operation, Productivity, Performance Measures and Appointment Types in Primary, Specialty, and Behavioral Health Care in Medical Treatment Facilities (MTFs),” February 4, 2020.

## ***Access to Care Measurement***

In the direct care system, the specialty access to care standard of 28 days is measured from the time the referral is ordered to the date of the MTF appointment.<sup>19</sup> Within the purchased care system, the specialty access to care standard of 28 days is measured from 3 days after the date the referral is approved to the date the service was provided.

In addition to the access to care measures mentioned above, DHA Procedural Instruction 6490.02 establishes an evidence-based treatment utilization rate and a treatment dosage rate.<sup>20</sup> The utilization rate measures the number and percentage of patients with a diagnosis of PTSD or major depressive disorder who received evidence-based (research proven) treatment across the MHS and by MTF. The treatment dosage rate measures the number and percentage of patients initially diagnosed with PTSD or major depressive disorder who met the requirement of being scheduled for an initial visit plus three or more follow-up visits within the first 90 days after their initial diagnosis.

## ***Mental Health System of Care***

In June 2007, the DoD Task Force on Mental Health reported that no single mental health program existed across the DoD and pointed out the considerable variation in mental health service delivery among the military Services and TRICARE. The report issued by the DoD Task Force on Mental Health stated, “the multiplicity of programs, policies, and funding streams...may also lead to confusion about benefits and services, fragmented delivery of care, and gaps in service provision.”

A May 2019 Report to Congress stated that the DHA's approach to an integrated system of care will be modeled after the Army's Behavioral Health System of Care.<sup>21</sup> According to the Chair of the DHA's Behavioral Health Clinical Community, as of December 2019, the DHA's Behavioral Health Clinical Community was “working on the standardization of the BH [Behavioral Health] Service Line enterprise wide... [and] socializing with leadership which elements of the [Army's] BHSOC [Behavioral Health System of Care] will be adopted by DHA.” The Army's 11 integrated behavioral health programs in support of health and readiness are:

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<sup>19</sup> Defense Health Agency Interim Procedures Memorandum 18-001.

<sup>20</sup> DHA Procedural Instruction 6490.02. Behavioral Health (BH) Treatment and Outcomes Monitoring, July 12, 2018, does not define the term “treatment dosage rate.” Based on comments made by DHA officials, treatment dosage includes frequency, duration, and nature of treatment provided. Treatments are considered “evidence-based” only after they are shown to be successful in controlled research studies. Patients are considered to have received evidence-based treatment within the direct care system for post-traumatic stress disorder and major depressive disorder if there is documentation of using one of the most recent Veterans Affairs / DoD Clinical Practice Guidelines or DoD guidance.

<sup>21</sup> Report to Congressional Armed Services Committees, House Report 115-676, pp. 132-133, to Accompany H.R. 5515, the National Defense Authorization Act for Fiscal Year 2019, Mental Health Care in the Military Health System, May 2019.

- Behavioral Health in Patient-Centered Medical Homes – Integrates behavioral health providers within primary care clinics that deliver care to active duty service members and their families in order to screen and treat common behavioral health problems.
- Child and Family Behavioral Health System – Behavioral health services to support military children, their families, and the Army community using school-based care, tele-consultation, and direct care services.
- Family Advocacy Program. – Provides domestic abuse, child abuse and neglect prevention (secondary and tertiary), education, prompt reporting, assessment, and treatment.
- Embedded Behavioral Health – Provides multidisciplinary community behavioral health care to Soldiers in close proximity to their units and in coordination with their unit leaders.
- Multi-Disciplinary Behavioral Health Services – Provides general and sub-specialty behavioral health services to Soldiers and their families through prevention, advocacy, and treatment.
- Intensive Outpatient Programs – Treats patients presenting with substance use disorders and/or behavioral health problems utilizing a multi-week intensive outpatient treatment strategy.
- Inpatient Behavioral Health Services – Provides inpatient behavioral health services to treat acute behavioral health crises to enable rapid symptom resolution and safe transfer of care to outpatient settings.
- Residential Treatment Facilities – Provides an interdisciplinary program in a 24-hour, live-in, multi-week setting targeting substance use disorders and other chronic conditions.
- Tele-Behavioral Health – Transmits behavioral health clinical capability virtually.
- Connect Care – Provides care management for Soldiers and their families referred to civilian inpatient facilities to ensure coordinated behavioral health care.
- Support of Traumatic Brain Injury.

### ***Prior Attempts at Developing and Implementing a Staffing Model***

In a 2007 Report to Congress detailing its plan of action for improving access to care, the DoD stated that it would expand staff using a comprehensive model that would identify how many and what type of staff are needed based on the risk involved in the communities they serve. In September 2013, the ASD(HA) asked the Services to nominate their choice of a mental health provider staffing model



that would be adaptable to all three Services and demonstrate clinical validity, to be used for the budget request to predict staffing. In 2014, the DoD selected the Psychological Health Risk Adjusted Model for Staffing (PHRAMS). In 2015, the GAO reported in Report 15-184 that the Services were not fully utilizing PHRAMS. Senate Report 114-255, accompanying the FY 2017 NDAA, directed the Service secretaries and National Capital Region Medical Directorate to review and report on the utility of PHRAMS to their Service or organization and report on any Service-specific methods they use or recommend to improve PHRAMS' utility. In response, the Office of the Under Secretary of Defense for Personnel and Readiness issued a Memorandum to Congress stating that MHS Governance decided that the use of PHRAMS in the National Capital Region Medical Directorate should be discontinued and no further funding provided.<sup>22</sup> The memorandum stated that Service models have evolved to a point where a stand-alone mental health requirements model provides no value over existing Service models.

### ***Military Medical Treatment Facility Sites Visited***

This evaluation focused on access to outpatient mental health care for active duty service members and their families delivered by the MHS in direct and purchased care. To evaluate our objectives, we reviewed public law; DoD, DHA, and TRICARE policies; and reports to Congress related to mental health access to care. We performed site visits and conducted interviews at the DHA and the Service Medical Commands. We reviewed and analyzed appointment booking and referral data and we visited and interviewed personnel at the following 13 locations:

- Irwin Army Community Hospital, Fort Riley, Kansas
- Kimbrough Ambulatory Care Center, Fort Meade, Maryland
- McDonald Army Health Center, Joint Base Langley-Eustis, Virginia
- Madigan Army Medical Center, Joint Base Lewis-McChord, Washington
- McConnell Air Force Base Medical Clinic, McConnell Air Force Base, Kansas
- Malcolm Grow Medical Clinic and Surgery Center, Joint Base Andrews, Maryland
- Langley Air Force Base Hospital, Joint Base Langley-Eustis, Virginia
- Naval Medical Center Camp Lejeune, Camp Lejeune, North Carolina
- Naval Medical Center Portsmouth, Portsmouth, Virginia
- Naval Hospital Bremerton, Bremerton, Washington

<sup>22</sup> The MHS governance structure was established to facilitate the decision making process; maintain oversight of DoD health care; and coordinate health programs, services, and benefits. The highest governing body in the MHS is the Senior Military Medical Action Council. The Medical Deputies Action Group reports to the Senior Military Medical Action Council and is supported by four supporting governing bodies.

- Naval Health Clinic Oak Harbor, Oak Harbor, Washington
- Walter Reed National Military Medical Center, Bethesda, Maryland
- Womack Army Medical Center, Fort Bragg, North Carolina

## Finding

### The DoD Did Not Consistently Meet Outpatient Mental Health Access to Care Standards

The DoD did not consistently meet outpatient mental health access to care standards for active duty service members and their families, in accordance with law and applicable DoD policies. Specifically, for the December 2018 to June 2019 time period, we found that:

- 7 of 13 MTFs (direct care system) or their supporting TRICARE network (purchased care system) did not meet the specialty mental health access to care standard each month. For example, in December 2018, 8 of 13 MTFs did not meet the 28-day access to care standard required by 32 CFR sec. 199.17. The supporting TRICARE network also did not meet the 28-day access to care standard for psychiatry in December 2018 in 12 of the 13 locations we visited.
- An average of 53 percent (4,415 of 8,328 per month) of all active duty service members and their families in the TRICARE East and West regions, identified as needing mental health care and referred to the purchased care system, did not receive care. The DHA's specialty access to care measures did not include patients identified as needing mental health care but who did not receive it.

Additionally, during our site visits between August and October 2019, 9 of 13 MTFs reported the inability to meet evidence-based (research proven) treatment or to monitor the prescribed behavioral health treatment dosage (including visit frequency), in accordance with DHA-PI 6490.02, which means the patient's follow-up treatment may have been delayed or did not occur.<sup>23</sup> For example, mental health staff at three MTFs stated that MTF providers were unable to provide psychotherapy follow-up at a frequency that may have been more beneficial to the patient (recommended treatment dosage). MTF behavioral health providers also stated that they were unable to provide follow-up treatment at the recommended treatment dosage. Also, the DHA's specialty mental health access to care measures did not include the MTF's ability to meet evidence-based treatment.

<sup>23</sup> DHA-PI 6490.02, Behavioral Health (BH) Treatment and Outcomes Monitoring, July 12, 2018.

The DoD did not consistently meet outpatient mental health access to care standards because the DHA:

- Did not have an MHS-wide model to identify appropriate levels of staffing in direct and purchased care. MTF staff at 11 of the 13 MTFs we visited stated that they would need more mental health staff to meet access to care standards or to care for both active duty service members and their families. The DHA relies on the Services' manpower and staffing models to determine MTF mental health staffing levels. The Service staffing models do not incorporate all of the data elements necessary to accurately define enrollee demand for outpatient mental health services and the staff needed to meet that demand. The managed care support contractors from the TRICARE East and West regions have separate staffing models to determine the number of required TRICARE civilian network providers, which exclude some information necessary to provide an accurate estimate of the number of mental health providers needed to meet patient demand.
- Published inconsistent and unclear access to mental health care policies. For example, the Health Affairs Policy 11-005 states that patients who are seen in primary care or who self-refer to behavioral health care are required to be seen within 7 days.<sup>24</sup> However, the TRICARE Policy Manual does not require this 7-day access to care standard for patients who choose to self-refer.<sup>25</sup> Additionally, on October 3, 2016, the DoD updated the TRICARE Policy Manual to eliminate unnecessary quantitative treatment limitations on mental health care. However, this change was not made in the Health Affairs Policy 11-005. We also found that the MTFs we visited lacked a definition of what constitutes an initial behavioral health assessment and what that assessment should include. Officials from the Service Medical Commands each stated that there was no overarching policy for what elements are included as part of an initial behavioral health assessment. Furthermore, we found that the MTFs we visited inconsistently interpreted and implemented the requirement for a centralized appointment system. For example, 10 of 13 MTFs we visited implemented a centralized appointment system for primary and other types of care but, in most cases, the behavioral health clinics still handled their own appointments.
- Did not have visibility of patients who attempted, but were unable, to obtain mental health appointments in the purchased care system. Specifically, the TRICARE East and West managed care support

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<sup>24</sup> Health Affairs Policy Memorandum 11-005 TRICARE Policy for Access to Care, February 23, 2011.

<sup>25</sup> TRICARE Policy Manual 6010.60-M, Chapter 7, Section 3.8 Treatment of Mental Disorders – General, April 1, 2015.



contractors were only able to determine whether a patient obtained an appointment after a claim was submitted and processed, which can take more than 90 days.

- Measured the 28-day specialty access to care standard differently between the direct and purchased care systems, both of which included only those patients who were able to get an appointment, excluded patients who self-referred, and considered only the patients' first appointment.

As a result, thousands of active duty service members and their family members may have experienced delays in obtaining mental health care. The delays may have involved numerous members not being able to: (1) see the right provider at the right time, (2) obtain mental health care at all, or (3) receive timely follow-up treatment. For example, in June 2019, active duty service members and their families who were referred to the TRICARE network waited, on average, 57 days (29 days over the standard) for behavioral health care and 79 days (51 days over the standard) for psychiatry at the Naval Health Clinic Oak Harbor. Delays in mental health care increase the risk of jeopardizing patient safety and can negatively affect the readiness of the force.

## **The DoD Did Not Consistently Meet Outpatient Mental Health Access to Care Standards**

The direct and the purchased care systems did not consistently meet outpatient mental health access to care standards for active duty service members and their families, in accordance with law and applicable DoD policies. We evaluated access to care for the December 2018 to June 2019 time period at 13 MTFs (direct care system) and their supporting TRICARE networks (purchased care system).

### ***MTFs Did Not Meet the 28-Day Access to Care Standard According to DHA Measures***

We found that 7 of 13 MTFs (direct care system) or their supporting TRICARE network (purchased care system) did not meet the specialty mental health access to care standard of 28 days in any month from December 2018 to June 2019.

Five of the remaining six MTFs met the access to care standard in both the direct and purchased care systems for only a single month each during the same reporting period. For example, in December 2018, 8 of 13 MTFs did not meet the 28-day specialty access to care standard required by 32 CFR sec. 199.17 (2019). In that same month, the supporting TRICARE network did not meet the 28-day access to care standard for psychiatry in 12 of the 13 locations we visited.

### ***Direct Care System***

Within the direct care system, data from three MTFs (Madigan Army Medical Center, Naval Hospital Bremerton, and Naval Health Clinic Oak Harbor) were not available due to reporting limitations of the new electronic health record, called MHS GENESIS.<sup>26</sup> MTF staff at these three facilities stated that they were unable to measure access to care due to reporting limitations of MHS GENESIS and that they had developed their own "stubby pencil" or "home grown" methods of measurement. As a result, system-generated standardized access to care reports were not available for those three MTFs during the reporting period. Of the remaining 10 MTFs, 6 did not consistently meet access to care standards, and 2 MTFs did not meet access to care standards at any time during the reporting period (Malcolm Grow Medical Clinic and Surgery Center and Naval Medical Center Portsmouth).<sup>27</sup> Two MTFs (Womack Army Medical Center and Naval Medical Center Camp Lejeune) met the mental health access to care standard the entire reporting period. During our site visits, 7 of 13 MTFs acknowledged that they were either not meeting or did not know if they were meeting outpatient specialty mental health access to care standards. Table 1 reflects the direct care system's access to care measure for specialty mental health care.

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<sup>26</sup> MHS GENESIS is the new electronic health record that provides enhanced, secure technology to manage patient health information. When fully deployed, MHS GENESIS will provide a single health record for service members, veterans, and their families.

<sup>27</sup> The remaining 10 MTFs used the Armed Forces Health Longitudinal Technology Application, the electronic medical record system used by the DoD since January 2004.

Table 1. Direct Care System Average Number of Days From Referral Ordered to MTF Appointment for Mental Health Care <sup>28</sup>

Service	Military Medical Treatment Facility	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Army	Irwin Army Community Hospital	33	20	24	28	24	25	24
Army	Kimbrough Ambulatory Care Center	31	29	31	32	30	29	27
Army	McDonald Army Health Center	30	19	29	29	23	28	21
Army	Madigan Army Medical Center							
Air Force	McConnell Air Force Base Medical Clinic*	45	28	16	31	12	28	16
Air Force	Malcolm Grow Medical Clinic and Surgery Center	33	36	34	31	30	34	37
Air Force	Langley Air Force Base Hospital	30	22	35	21	25	28	22
Navy	Naval Medical Center Camp Lejeune	26	20	21	23	21	20	21
Navy	Naval Medical Center Portsmouth	36	34	37	29	32	38	33
Navy	Naval Hospital Bremerton							
Navy	Naval Health Clinic Oak Harbor							
Defense Health Agency	Walter Reed National Military Medical Center	30	26	28	31	31	31	32
Defense Health Agency	Womack Army Medical Center	22	19	21	23	23	22	21

\*McConnell Air Force Base Medical Clinic had less than five mental health referrals that were documented as “Appoint to MTF” in the months of December 2018, January 2019, March-June 2019.

Green = Met the 28-day specialty access to care standard. (28 days or less)

Red = Did NOT meet the-28 day specialty access to care standard. (More than 28 days)

Black = Data was not available.

<sup>28</sup> Data Source: TRICARE Operations Center website - <https://info.health.mil/staff/analytics/atcreports/Pages/apptreports.aspx>.

"MTF Specialty Care Referral Detail Report" Filtered by the following:

"Refer to MEPRS 3" = BFA, BFB, BFC, BFD, BFE

"Appointment Request Status" = APPOINT TO MTF

"Bencat" = ACT (Active Duty), DA (Dependents of Active Duty), GRD (Guard/Reserve on Active Duty), DGR (Dependent of Guard/Reserve on Active Duty)

***Purchased Care System***

We determined that the supporting TRICARE network at all 13 MTFs did not consistently meet the standard for active duty service members and their families who were enrolled to the MTFs and received mental health care from the purchased care system. The purchased care system referral data separates mental health care into two categories, behavioral health and psychiatry. The purchased care system supporting one MTF (Madigan Army Medical Center) did not meet access to care standards for the entire reporting period for behavioral health care and five MTFs only met access to care standards for one month each.

The purchased care system supporting 12 of the 13 MTFs we visited did not meet the 28-day access to care standard for psychiatry in the month of December 2018. Tables 2 and 3 display the purchased care system's measure of access to care for behavioral health and psychiatry, respectively.

*Table 2. Purchased Care System Behavioral Health Average Number of Days from Referral Approved, Plus Three Days, to Appointment by Ordering Parent MTF <sup>29</sup>*

Service	Military Medical Treatment Facility	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Army	Irwin Army Community Hospital*	34	46	43	34	43	50	26
Army	Kimbrough Ambulatory Care Center	25	24	26	24	33	40	31
Army	McDonald Army Health Center	16	38	38	22	21	25	19
Army	Madigan Army Medical Center	39	38	39	38	31	42	52
Air Force	McConnell Air Force Base Medical Clinic	28	35	16	39	26	36	16
Air Force	Malcolm Grow Medical Clinic and Surgery Center*	23	16	20	21	15	39	21
Air Force	Langley Air Force Base Hospital	33	26	16	18	22	27	39
Navy	Naval Medical Center Camp Lejeune	41	35	40	26	33	33	32
Navy	Naval Medical Center Portsmouth	27	28	29	37	29	32	25
Navy	Naval Hospital Bremerton	30	38	25	47	33	29	46
Navy	Naval Health Clinic Oak Harbor	31	39	38	25	56	33	57
Defense Health Agency	Walter Reed National Military Medical Center	14	30	31	33	42	43	18
Defense Health Agency	Womack Army Medical Center	30	32	33	27	31	33	30

\* Indicates the MTF had less than five mental health referrals that resulted in an appointment for that month (Irwin Army Community Hospital - June 2019 and Malcolm Grow Medical Clinic and Surgery Center - December 2018)

Green = Met the 28-day specialty access to care standard. (28 days or less)

Red = Did NOT meet the 28-day specialty access to care standard. (More than 28 days)

<sup>29</sup> Data Source: DoD OIG generated from the East and West TRICARE Managed Care Support Contractors' Access Standards Report filtered by the following:  
 "Beneficiary Category" = AD (Active Duty), ADD (Active Duty Dependent) for the East Region and ADSM (Active Duty Service Member) and ADFM (Active Duty Family Member) for the West Region  
 "Care Rendered" = Y for the East Region and Yes for the West Region  
 "Retro Care" = N for the East Region and No for the West Region

Table 3. Purchased Care System Psychiatry Average Number of Days from Referral Approved, Plus Three Days, to Appointment by Ordering Parent MTF <sup>30</sup>

Service	Military Medical Treatment Facility	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Army	Irwin Army Community Hospital*	41	55	76	19	28	64	25
Army	Kimbrough Ambulatory Care Center	33	40	44	27	25	25	19
Army	McDonald Army Health Center*	36	24	44	30	38	27	40
Army	Madigan Army Medical Center*	50	18	46	30	40	34	46
Air Force	McConnell Air Force Base Medical Clinic*	40	34	23	23	39	18	29
Air Force	Malcolm Grow Medical Clinic and Surgery Center*	61	23	57	51	19	9	36
Air Force	Langley Air Force Base Hospital	35	28	46	35	31	28	41
Navy	Naval Medical Center Camp Lejeune	32	34	25	27	38	35	45
Navy	Naval Medical Center Portsmouth	37	24	29	38	36	34	41
Navy	Naval Hospital Bremerton*	56		23	90	47	14	43
Navy	Naval Health Clinic Oak Harbor*	6	34	39	118	56	81	79
Defense Health Agency	Walter Reed National Military Medical Center*	43	79	55	49	58	32	9
Defense Health Agency	Womack Army Medical Center	33	30	28	27	30	25	27

\* Indicates the MTF had less than five mental health referrals that resulted in an appointment for that month (Irwin Army Community Hospital - May-June 2019; McDonald Army Health Center - March, April, May 2019; Madigan Army Medical Center - December 2018; McConnell Air Force Base Medical Clinic - February and June 2019; Malcolm Grow Medical Clinic and Surgery Center - January and June 2019; Naval Hospital Bremerton - May-June 2019; Naval Health Clinic Oak Harbor - December 2018, January-March 2019, May-June 2019; Walter Reed National Military Medical Center - April and June 2019)

Green = Met the 28-day specialty access to care standard. (28 days or less)

Red = Did NOT meet the-28 day specialty access to care standard. (More than 28 days)

Black = No Data

<sup>30</sup> Data Source: DoD OIG generated from the East and West TRICARE Managed Care Support Contractors' Access Standards Report filtered by the following:  
 "Beneficiary Category" = AD (Active Duty), ADD (Active Duty Dependent) for the East Region and ADSM (Active Duty Service Member) and ADFM (Active Duty Family Member) for the West Region  
 "Care Rendered" = Y for the East Region and Yes for the West Region  
 "Retro Care" = N for the East Region and No for the West Region



## ***More Than Half of the Active Duty Service Members and Their Families Did Not Use Their Mental Health Referrals to the TRICARE Network***

The DoD could have thousands of active duty service members and members of their families that need mental health care that are not receiving it. The DHA provided the TRICARE East and West managed care support contractors' Access Standards Reports for their entire regions. According to those reports, of all active duty service members and their families in the TRICARE East and West regions identified as being referred to the purchased care system for mental health care between December 2018 and June 2019, an average of 53 percent (4,415 of 8,328 per month) did not receive mental health care from a TRICARE civilian provider. In comparison, for all specialty care combined, 36 percent of patients referred to TRICARE civilian providers in the East and West region did not receive care, notably less than mental health care. Although the percentage of unused referrals is reported by the TRICARE managed care support contractors, the DHA does not use the percentages reported as a measure of access to care. The DHA did not include in its access to care measures those patients identified and referred for mental health care but who did not receive such care. This is discussed in more detail later in the report.

## ***MTFs Reported Their Inability to Meet Evidence-Based Treatment Guidelines or Monitor Treatment Dosage***

During our site visits between August and October 2019, 9 of 13 MTFs reported the inability to meet evidence-based treatment or monitor the prescribed behavioral health treatment dosage in accordance with DHA-PI 6490.02, which means the patient's follow-up treatment may have been delayed or did not occur.<sup>31</sup> For example, a Director for Mental Health at one MTF stated that access to psychotherapy at that MTF is "systematically below the standard of care" because the MTF was only able to provide monthly psychotherapy, when weekly or more frequent sessions may have been more beneficial for the patient. The staff at that MTF stated that they provided "safety checks vs. treatment" for patients because they were unable to meet evidence-based treatment guidelines for visit frequency.

<sup>31</sup> DHA Procedural Instruction 6490.02. Behavioral Health (BH) Treatment and Outcomes Monitoring, dated July 12, 2018, does not define the term "treatment dosage rate." Based on comments made by DHA officials, treatment dosage includes frequency, duration, and nature of treatment provided. Treatments are considered "evidence-based" only after they are shown to be successful in controlled research studies. Patients are considered to have received evidence-based treatment within the direct care system for post-traumatic stress disorder and major depressive disorder if there is documentation of using one of the most recent Veterans Affairs / DoD Clinical Practice Guidelines or DoD guidance.

A mental health provider at the same MTF also stated that it could take up to 7 weeks for a follow-up visit and that “the clinic is not tracking how well they can treat a patient once the patient is in the clinic.”

An MTF Commander at another MTF stated, “When you have so many new patients...you are unable to maintain follow-up and maintain their safety.”

A mental health provider at another MTF stated that when the MTF was fully staffed they could do weekly therapy, but at the time of our interview, follow-up appointments were challenging due to staffing shortages. In a 2019 Report to Congress, officials from the DHA’s National Capital Region stated that, due to current behavioral health demand exceeding available provider capacity, providers are unable to provide therapeutic interventions at reasonable and safe intervals consistent with treatment dosage targets outlined in DHA-PI 6490.02. In 2007, the DoD Task Force on Mental Health also found that sufficient mechanisms were not in place to assure the use of evidence-based (research proven) treatments.

### **DHA Did Not Have an MHS-Wide Staffing Model, Consistent Policies and Measures for Direct and Purchased Care, or Visibility of Patients Unable to Obtain Mental Health Care**

The DoD did not consistently meet outpatient mental health access to care standards for patients trying to make appointments. This inability to meet standards for appointment availability was partially due to the DHA not having an MHS-wide model to identify appropriate levels of staffing in direct and purchased care. Additionally, the DHA published inconsistent and unclear policies for access to outpatient mental health care and measured the 28-day specialty access to care standard differently between the direct and purchased care systems. The DHA also did not have visibility of patients who attempted, but were unable, to obtain mental health appointments in the purchased care system.

#### ***The DHA Lacked a Standardized Mental Health Staffing Model***

The DHA did not have an MHS-wide model to identify appropriate levels of staffing in direct and purchased care. MTF staff at 11 of the 13 MTFs we visited stated that they would need more mental health staff to meet access to care standards or to care for both active duty service members and their families. A November 2019 report submitted to Congress by the Assistant Secretary of Defense for Manpower and Reserve Affairs, Performing the Duties of the Under Secretary of Defense for Personnel and Readiness, stated that, particularly in rural locations without a robust TRICARE network, there is a mismatch between military and civilian staffing to meet the need of active duty family members. It also stated that military and civilian child and adolescent mental health providers

are particularly difficult to recruit. The report also described the impediments to recruiting and retaining civilian and military mental health providers across the MHS, including non-commensurate pay relative to private sector counterparts, the amount of time it takes to process hiring actions, and a national shortage of providers. According to the National Center for Health Workforce Analysis, there was an estimated shortage of 9,050 psychiatrists in the United States for 2016 and a projected shortage of 17,430 psychiatrists by the year 2030, taking unmet needs into consideration.<sup>32</sup>

Staffing MTFs to ensure sufficient providers are available to meet demand has been a long-standing issue. In a 2007 Report to Congress, the Under Secretary of Defense for Personnel and Readiness stated that development of a comprehensive model to identify how many and what types of mental health staff are needed would improve access to care. In September 2013, the ASD(HA) asked the Services to nominate their choice of a mental health provider staffing model that would be adaptable to all three Services, and, in 2014, the DoD selected the Psychological Health Risk Adjusted Model for Staffing (PHRAMS). In 2017, the Office of the Under Secretary of Defense for Personnel and Readiness issued a Memorandum to Congress stating that the Service models have evolved to a point where a stand-alone mental health requirements model provides no value over existing Service models. Therefore, mental health staffing levels at the MTFs and in the TRICARE network are currently determined, in part, by an assortment of models developed by the DHA, the military Services, and the TRICARE managed care support contractors.

In both the direct and purchased care systems, only a portion of a provider's time is spent delivering patient care to enrolled beneficiaries. Information about the number of mental health appointments available to enrolled beneficiaries, per provider, should be incorporated into the model. Additionally, because MTF enrollee populations have different demographics, mental health conditions, and condition severity, an MHS staffing model can adjust for these differences by estimating staff and appointment supply based on population needs.

We conducted interviews with the DHA and the Services to understand who is responsible for identifying the number of providers needed to meet mental health demand. As of October 1, 2019, the DHA is responsible for development of MTF manpower requirements; however, according to the DHA Branch Chief for Planning and Programming, Manpower and Organization, the DHA plans to rely on the Services' Manpower and Staffing models until the DHA is able to

<sup>32</sup> State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030, U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, National Center for Health Workforce Analysis, September 2018.

build models across functional areas. The managed care support contractors from the TRICARE East and West regions also used their own staffing models to determine the number of TRICARE civilian network providers required to provide mental health services to service members and their families. We requested and reviewed the methods used in the Services' and managed care support contractors' staffing models.

The Service staffing models do not incorporate all of the data elements necessary to accurately define enrollee demand for outpatient mental health services and the staff needed to meet that demand. Each Service applies its own methods to determine mental health staffing requirements. Some, or all, of the Service staffing models do not account for the following:

1. *Evidence-based guidelines for treatment of mental health conditions.* Service staffing models quantify patient demand based on historical utilization by patients rather than evidence-based treatment dosage. Historical utilization accounts for only the patients who were seen based on the current staffing levels of the MTF; it does not represent the number of patients who need to be seen or the number of providers needed to meet the appropriate behavioral health treatment dosage. Therefore, the Service staffing models underrepresented the required number of providers needed to perform evidence-based treatment.
2. *Embedded mental health providers and the workload generated in an embedded mental health setting.* Each Service has developed its own version of an embedded mental health program to support the needs of operational units. While the Navy and the Air Force embedded mental health programs are under the command and control of operational commanders, the Army has two different programs for embedded mental health. The Army embedded behavioral health program is staffed with civilian providers who are aligned to support specific operational units but fall under the command and control of the MTF. The Army also has active duty behavioral health officers who are assigned to and under the command and control of the operational command. We determined that the Service staffing models did not always include embedded mental health personnel or the amount of mental health care provided by embedded personnel. For example, the Navy Bureau of Medicine and Surgery stated that its staffing model did not adequately address embedded mental health providers, and an official from one Navy embedded mental health program stated that the process to determine the number of embedded mental health billets is not standardized and a manpower study is needed. Additionally, the DHA stated that it has no authority over Service embedded personnel who are assigned

to operational commands. This means that the DHA will not have any control over the placement of these providers when it assumes responsibility over the manpower requirements process.

3. *Total utilization-based mental health demand for enrolled beneficiaries.* The Services based their MTF personnel requirements on the amount of workload historically provided by direct care mental health providers, not on the total amount of workload generated by providers in the direct and purchased care systems. For example, the Army determines mental health provider requirements for Army MTFs based on its provider's patient care and non-patient-care workload. The Army's behavioral health service line developed a model called the distribution matrix tool, which estimates MTF staffing requirements relative to direct care workload and a percentage of purchased care workload; however, these estimates do not supersede official Army model estimates. According to a December 2019 document provided by the Navy Bureau of Medicine and Surgery, detailing its Shore Manpower Requirements Determination Process, the Navy also uses historical MTF workload to quantify total MTF manpower requirements.

The two managed care support contractors used different methods to estimate the number of providers needed to meet beneficiary demand for mental health services. Both the TRICARE East and West managed care support contractors submit a monthly Network Adequacy Report to DHA, based on provider network sizing models. These reports reflect the number of contracted providers relative to the anticipated number of providers needed. However, the network adequacy reports do not include providers' appointment availability or whether appointments are available within the access to care standard. Because TRICARE patients make up only a percentage of a civilian provider's practice, the staffing model must account for the number of appointments available within access standards to enrolled beneficiaries in the TRICARE network. The TRICARE East managed care support contractor based its provider estimates on the total number of TRICARE-eligible beneficiaries in an area, while the TRICARE West managed care support contractor based its staffing estimates on historical TRICARE beneficiary utilization data. The managed care support contractor models adjust for the fact that network providers do not provide care to TRICARE beneficiaries 100 percent of the time. However, the adjustment is based on the amount of care historically provided by network providers to TRICARE-eligible beneficiaries, not the number of mental health appointments available within access standards with those providers. Therefore, the models do not accurately estimate the number of network providers needed to meet TRICARE beneficiary demand for appointments, within mental health access to care standards.

Because the Service and managed care support contractors' models differ from each other, there was no comprehensive MHS-wide staffing model that estimated the number of providers needed to meet the mental health needs of active duty service members and their families. Furthermore, the Service and managed care support contractor staffing models exclude some information necessary to provide an accurate estimate of the number of mental health providers needed to meet patient demand for services.

### ***The DHA Published Inconsistent and Unclear Access to Mental Health Care Policies***

The DHA published inconsistent and unclear policies for access to outpatient mental health care. For example, Health Affairs Policy 11-005 states that the access to care standard to perform a non-urgent initial behavioral health assessment is considered routine care (7 days) if the patient:

- seeks treatment within primary care, or
- self-refers to a specialty mental health clinic.<sup>33</sup>

However, the TRICARE Policy Manual's section on the treatment of mental disorders does not require this 7-day access to care standard for patients who choose to self-refer to an authorized TRICARE network provider for outpatient mental health services.<sup>34</sup> Furthermore, the DHA IPM 18-001 has both a 7- and a 28-day standard for the initial non-urgent behavioral health visit in a specialty mental health clinic.

The staff at all of the MTFs we visited interpreted the access to care standard for the first mental health visit in the specialty mental health clinic differently and implemented policies differently due to the inconsistency between the Health Affairs Policy 11-005 and the DHA IPM 18-001. For example, one MTF's access to care policy had a 7-day standard for the initial behavioral health appointment for any patient, regardless of whether the visit resulted from a referral or the patient initiated a self-referral. A representative at another MTF stated that their goal was to have active duty service members seen within 15 days. A mental health staff member at another MTF stated that the access to care standard for first-time referrals was 7 days, and a mental health staff member at a fourth MTF stated the DHA IPM changed the standard from 7 days to 28 days.

<sup>33</sup> Health Affairs Policy Memorandum 11-005 TRICARE Policy for Access to Care, February 23, 2011, and Defense Health Agency-Interim Procedures Memorandum (DHA IPM) 18-001, "Standard Appointing Processes, Procedures, Hours of Operation, Productivity, Performance Measures and Appointment Types in Primary, Specialty, and Behavioral Health Care in Medical Treatment Facilities (MTFs)" February 4, 2020.

<sup>34</sup> TRICARE Policy Manual 6010.60-M, Chapter 7, Section 3.8 Treatment of Mental Disorders – General, April 1, 2015.



Two senior leaders at the National Capital Region Medical Directorate acknowledged and confirmed the inconsistency between the 7-day standard contained in Health Affairs Policy 11-005 and the 7- and 28-day standards contained in DHA IPM 18-001 for the initial non-urgent behavioral health assessment.

### ***Policies for Quantitative Treatment Limitations and for Outcome Measurement Contained Inconsistent Guidance for Implementation***

The ASD(HA) policy memorandum restricting the number of mental health care visits was not consistent with the updated TRICARE Policy Manual. Health Affairs Policy 11-005 requires a quantitative treatment limitation of eight visits for outpatient mental health visits. However, on October 3, 2016, in an effort to expand access to mental health services, the DoD eliminated all unnecessary quantitative treatment limitations on mental health care. The TRICARE Policy Manual documented this change, but the Health Affairs Policy 11-005 did not. During our site visits, we found that staff at one MTF only approved a limited number of visits and they told active duty family members they could have eight visits to the network without a referral.

The requirements in DHA Procedural Instruction 6490.02, Enclosure 3, Procedures, section 2b, that dictate the timing of outcome measurement (evaluation of the patient's behavioral health) were inconsistent with section 6c of that same document.<sup>35</sup> In addition, the TRICARE Policy Manual (Psychotherapy) was not consistent with either section of DHA Procedural Instruction 6490.02.<sup>36</sup> As early as 2013, the ASD(HA) recognized the benefits of outcome measurement as a way to evaluate effectiveness of mental health programs. As a result, the ASD(HA) identified outcome measurement in mental health to be an area in need of immediate improvement.

DHA Procedural Instruction 6490.02 section 2b requires outcome measurement in behavioral health specialty care clinics at baseline (administered closest to the date of diagnosis) and no less frequently than every 30 days.<sup>37</sup> However, section 6 of the policy instruction requires measurement by behavioral health care facilitators in primary care clinics at first contact (within 10 days of referral from the primary care manager), 4 weeks after initial diagnosis, and every 4 weeks

<sup>35</sup> DHA-PI 6490.02, Behavioral Health (BH) Treatment and Outcomes Monitoring, July 12, 2018.

<sup>36</sup> TRICARE Policy Manual 6010.60-M, April 1, 2015, Chapter 7, Section 3.11, Psychotherapy Issue Date: December 5, 1984, Revision: C-13, November 15, 2017.

<sup>37</sup> DHA-PI 6490.02, Behavioral Health (BH) Treatment and Outcomes Monitoring, July 12, 2018. Outcome measures include Patient Health Questionnaire (PHQ)-9 for Major Depressive Disorder (MDD), Post Traumatic Stress Disorder (PTSD) Check List (PCL-5) for PTSD.

thereafter. The 10-day window allowed by this policy could result in a delay in initial measurement of up to 10 additional days after diagnosis. Subsequent measurements are set for 28 days in primary care, 2 days sooner than the 30-day minimum frequency required in behavioral health specialty care clinics.

Moreover, the TRICARE Policy Manual (Psychotherapy) only requires measurement in purchased care at baseline, at 60 to 120-day intervals, and at discharge, for PTSD and MDD. The inconsistencies between DHA Procedural Instruction 6490.02 and the TRICARE Policy Manual resulted in a delay in measurement for TRICARE patients of as much as 90 days beyond the 30-day interval described in the DHA procedural instruction for behavioral health specialty care clinics.

### ***Initial Behavioral Health Assessment Lacks a Common Definition***

The MTFs we visited also lacked a definition of, or minimum required elements for, what constitutes an initial behavioral health assessment and what that assessment should include. When asked whether a policy existed that defines an initial behavioral health assessment, personnel from the Service medical commands each responded that there was no overarching policy.

Nine of the thirteen MTFs used one or more of five strategies to meet access to care standards for non-urgent outpatient mental health care. No standard definition or minimum required elements exist; therefore, we determined that MTFs did not use a standard way to evaluate when mental health care begins.

1. At least three MTFs (Womack Army Medical Center, Naval Health Clinic Oak Harbor, and Naval Hospital Bremerton) utilized group therapy appointments as an assessment tool or as interim therapy until a patient was able to see an individual provider.
2. At one MTF (Naval Hospital Bremerton), if a patient self-referred, the patient was sent back to their primary care manager.
3. At least six MTFs (Naval Medical Center Portsmouth, Womack Army Medical Center, Naval Medical Center Camp Lejeune, Naval Health Clinic Oak Harbor, Walter Reed National Military Medical Center, and Malcolm Grow Medical Clinic and Surgery Center) implemented a triage process. At one MTF, the delay for a patient's behavioral health care needs to be evaluated through the triage process was 21 days. This site reported that their usual triage time is a delay of 7 to 10 days.
4. One MTF (Malcolm Grow Medical Clinic and Surgery Center) utilized psychologists as a "gatekeeper" to screen patients before appointing them to a psychiatrist.

5. At six MTFs (Womack Army Medical Center, Naval Medical Center Camp Lejeune, Naval Health Clinic Oak Harbor, Madigan Army Medical Center, Irwin Army Community Hospital, and Malcolm Grow Medical Clinic and Surgery Center), psychiatric technicians completed an intake. At Naval Hospital Bremerton, staff acknowledged that they previously used psychiatric technicians for intake but realized that practice caused a delay in access to care because, as stated by a provider at Naval Hospital Bremerton, having an active duty service member see a behavioral health technician is not providing access to mental health care.

### ***Centralized Appointment Booking Required by the FY 2017 NDAA and DHA IPM 18-001 Was Not Implemented for Behavioral Health Appointments***

Centralized appointment booking required by the FY 2017 NDAA and DHA IPM 18-001 was not implemented for behavioral health appointments. The FY 2017 NDAA states that each MTF must use a centralized appointment scheduling capability for covered beneficiaries that includes the ability to schedule appointments manually via telephone or automatically via a device connected to the Internet through an online scheduling system.<sup>38</sup> DHA IPM 18-001 requires that MTFs establish a centralized appointment system at the MTF for behavioral health services. Both the DHA IPM dated July 3, 2018, and the reissued guidance dated July 12, 2019, and February 4, 2020, all required establishment of a centralized appointment system within 6 months of the guidance issue date.

Despite this requirement, we found that the MTFs we visited inconsistently interpreted and implemented the requirement for a centralized appointment system. For example, 10 of the 13 MTFs we visited centralized their appointments for primary and other types of care, but the behavioral health clinics still handled most or all of their own appointments. One MTF official stated that patients can call the front desk of the mental health clinic and their interpretation of the DHA IPM was that if a patient can call one number and get their needs met, then the MTF met the intent of the policy. Another MTF official stated that the MTF has centralized appointing, but the behavioral health clinic handled its own referrals within the MTF and to the network. An official at a third MTF described centralized booking as the coordination between central booking and the behavioral health clinic. Staff at the MTFs offered various reasons for not using centralized appointing, including lack of sufficient staff in the appointing center and appointment clerks who were unable to identify correct providers or understand

<sup>38</sup> Public Law 114-328, December 23, 2016.

the nuances in behavioral health appointment booking, such as specialties or types of providers. Personnel at one facility described their past efforts to centralize behavioral health booking as a ‘nightmare.’

In contradiction to DHA IPM 18-001, DHA staff members stated that the current DHA IPM does not require centralized appointing but does require a centralized way to get patient needs met. The DHA does not currently track centralized appointing capability but is looking at whether a centralized appointment center model can support MTFs.

### ***Best Practice for Implementing Centralized Appointing***

Irwin Army Community Hospital at Ft. Riley, Kansas, implemented a system maximizing the use of automated services and centralized appointing resources. At that facility, patients call a single number. The phone line for the behavioral health clinic is forwarded to the central appointment booking line to ensure that all calls go to a single location. When the patient calls, the patient may choose behavioral health and select the unit, an action that directs the call to the front desk of the behavioral health clinic. The central referral management and appointments supervisor can monitor the calls and evaluate how the calls are being handled. Central referral management appointments staff can alert the clinic of any issues, intercept calls if needed, and assist the clinic if they are getting more calls than they can handle.

### ***The DHA Did Not Have Visibility of Patients Who Attempted but Were Unable to Obtain Mental Health Appointments in the Purchased Care System***

The DHA did not have visibility of patients who attempted, but were unable, to obtain mental health appointments in the purchased care system. According to TRICARE Policy Manual 6010.60-M, the contractor assists the patient in locating an MTF or network provider to provide specialty care and in scheduling an appointment.<sup>39</sup> The 2007 Department of Defense Task Force on Mental Health also recommended that the DoD require:

- TRICARE contractors and subcontractors for mental health services to monitor, at least quarterly, whether network mental health providers are accepting new patients; and
- TRICARE contracts to include a case management system for mental health referrals, which should include a means for obtaining timely assistance in securing an appointment.

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<sup>39</sup> TRICARE Policy Manual 6010.60 M, April 1, 2015, Chapter 1, Section 7.1.

However, the managed care support contractors did not make appointments for patients and are only able to know whether a patient obtained an appointment after a claim is rendered and processed. This process may take more than 90 days after a referral is generated. This process leaves the referring provider, the MTF, and the managed care support contractor with a lack of visibility of those patients who sought an appointment but were unable to get one or were unable to schedule an appointment in a timely manner.

### ***Patients Must Use a Provider Directory Known to Be Inaccurate***

We found that the purchased care process left the patient responsible for making an appointment using an inaccurate online provider directory, which complicated access and delayed care. According to a DHA TRICARE Health Plan representative, the managed care support contractor notifies the patient by either postal mail or within their online patient portal that the patient has a referral. The managed care support contractor for the TRICARE East region selects a provider and lists the contact information from the online directory for the patient to call and attempt to get an appointment. The managed care support contractor for the TRICARE West region also selects a provider and notifies the patient via the patient portal. If the patient is unable to book an appointment with the selected provider within the “four weeks TRICARE access standard,” the managed care support contractor directs the patient to the provider online directory to choose a provider and the patient is responsible for making an appointment with the provider they select based on the information on the website. The Deputy Chief and Chief Clinical Officer of the TRICARE Health Plan stated that the TRICARE provider online directories in both the TRICARE East and West regions have not been accurate to the required 95 percent for the entire duration of the contract, which began January 1, 2018. The managed care support contractors responsible for the online directories have been on a corrective action plan for addressing contract deficiencies. According to MTF staff and documented patient complaints, patients contacted providers who were not available to take new TRICARE patients, which required calling multiple providers to get an appointment. The extent of the delays and the number of patients unable to obtain care was unknown because of the current processes for booking an appointment within the purchased care system. At least one MTF had a dedicated MTF referral management staff who tried to book the patients appointments with the TRICARE civilian providers using a list that they created internally because of the inaccuracies of the provider lists generated by the managed care support contractor.

Concerns with the TRICARE network have been an ongoing issue for nearly 2 decades. In 2000, the Government Accountability Office conducted an evaluation in response to beneficiary complaints about beneficiary difficulties trying to obtain care, including beneficiary concerns about the adequacy of civilian networks that the DoD uses to supplement care provided in MTFs.<sup>40</sup> The report recommended that the TRICARE managed care support contractors be required to maintain an accurate, up-to-date list of network providers that would indicate whether they were accepting new patients. The report also stated that one determining factor for an adequate network was whether a beneficiary had a qualified provider available within the access to care standards.

### ***DoD Mental Health Stakeholders Were Concerned With the Adequacy of the TRICARE Network***

MTF and unit staff at 12 of the 13 MTFs we visited had multiple concerns with the local supporting TRICARE network. At least five MTFs conducted their own studies of their local TRICARE network using either an internally developed survey, a review of purchased care access, or a collection of patient feedback. MTF staff members stated that the reviews indicated that patients reported an inability to get an appointment in the local TRICARE network, and many of the patients asked to be seen at an MTF. A referral management audit log given to us by one MTF behavioral health staff member showed several examples of patients referred either to the wrong type of provider, to providers no longer practicing in that state, or to providers with inaccurate contact information. One MTF conducted a reoccurring survey of its TRICARE behavioral health providers because the provider directory was incorrect. The staff from that MTF provided documentation from their recent surveys showing that, of the 125 providers listed, they found duplicate providers, 11 providers who were no longer in practice, and 26 providers who were not taking new TRICARE patients. A representative from the U.S. Army Medical Command stated that one of the access to care challenges experienced by the Army is an “inadequate network to absorb beneficiaries.”

According to the TRICARE East managed care support contractor, as documented in their access to care plan, stated network inadequacy is defined as any failure to provide healthcare services by a network provider within the access standards. The supporting TRICARE networks at the MTFs we visited did not consistently meet the access to care standard for patients who were enrolled at the MTFs but who received mental health care from the purchased care system. Therefore, by the TRICARE East managed care support contractor’s definition, the TRICARE network was inadequate. Both the TRICARE East and West managed care support

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<sup>40</sup> In 2000, the Government Accountability Office was called the General Accounting Office.



contractors submit a monthly Network Adequacy Report to the DHA. This report reflects the number of contracted providers relative to the anticipated number of providers needed. This report does not include providers' appointment availability. It also does not consider whether appointments are available within the access to care standard. In May 2020, the Government Accountability Office published a report stating that the civilian health care assessments did not consistently account for access to an accurate and adequate number of providers near MTFs and made the recommendation to collect complete and accurate information about the extent to which current health care providers within the TRICARE network meet access to care standards and assess that information to inform recommendations on future MTF restructuring decisions.

### ***The DHA Measured Access to Care Differently Between Direct and Purchased Care***

The DHA measured the 28-day specialty access to care standard differently between the direct and purchased care systems, both of which:

- included only those patients who were able to get an appointment,
- excluded patients who self-referred, and
- considered only the patients' first appointments.

For example, the start date to measure the 28-day access to care standard differed between the direct and purchased care systems. The start date within the direct care system commences the date the referral is ordered. The start date within the purchased care system, however, is 3 days after the referral is approved. In addition, the start date is reset if the assigned TRICARE civilian provider is updated on the referral. Therefore, in purchased care, the specialty access to care measure did not include the number of days between the date the referral was ordered to the date the referral was approved. Not including the number of days between the date the referral was ordered to the date the referral was approved underrepresented the actual wait time for the patient.

As previously stated, 53 percent of the patients identified in the TRICARE East and West regions as being referred to the purchased care system for mental health services between December 2018 and June 2019 never received care.<sup>41</sup> According to a journal article on compliance with referrals to medical specialist care published on the U.S. National Library of Medicine, National Institutes of Health website, the reasons why patients do not use their referrals include the belief that the health problem is resolved, a lack of time to attend the appointment, or long waiting times to gain an appointment. However, not using the referral

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<sup>41</sup> Based on data from the East and West TRICARE managed care support contractors' Access Standards Report.

may result in delayed diagnosis and treatment and poorer health outcomes. Personnel at various levels of the MHS could better evaluate and address access to care if they fully understood why a patient did not use his or her specialty mental health referral.

Additionally, the MTF commander determines how many non-active duty enrollees may be treated in the MTF specialty mental health clinic, based on demand and supply. At least 6 of the 13 MTFs only see active duty service members, deferring active duty family members to the TRICARE network. At least four MTFs acknowledged that they also deferred active duty service members to the TRICARE network. Behavioral health clinic staff at Walter Reed National Military Medical Center stated that each MTF in the National Capital Region decides which beneficiary categories they are willing to serve, allowing the MTF to change to serve active duty service members only. By limiting the MTFs' specialty mental health care services to active duty service members only, the behavioral health clinic staff stated the MTF manipulates the access to care measures. The DHA is also not monitoring the access to care for those patients who choose to self-refer to a specialty mental health clinic in either the direct or purchased care, to determine whether it meets the 7-day access to care standard for these patients.

## **Delays in Mental Health Access to Care May Have Jeopardized Patient Safety and Active Duty Service Member Readiness**

As a result, thousands of active duty service members and their families may have experienced delays in obtaining mental health care. There were 411,000 active duty service members and members of their families enrolled at the 13 MTFs that we visited. There were also over 58,000 referrals (over 8,000 per month) for behavioral health and psychiatry sent to the purchased care system in the TRICARE East and West Regions between December 2018 and June 2019, which does not include the number of beneficiaries who attempted to self-refer. The delays may have involved numerous members not being able to: (1) see the right provider at the right time, (2) obtain mental health care at all, or (3) receive timely follow-up treatment. For example, in June 2019, active duty service members and their families who were referred to the TRICARE network waited, on average, up to 57 days (29 over the standard) for behavioral health care and 79 days (51 days over the standard) for psychiatry at Naval Health Clinic Oak Harbor. All of these types of delays in mental health care increase the risk of jeopardizing patient safety and affecting the readiness of the force.

At another MTF, a psychiatrist specializing in child and adolescent care provided our team with three examples of how delayed access to outpatient mental health treatment may have contributed to patient safety issues, specifically second suicide attempts and hospitalization. Behavioral health clinic staff at an MTF provided the following written patient complaint, which reflected the patient's experience accessing behavioral health care in the direct and purchased care systems.

"This facility is inadequately staffed to the point of negligence. If a Service Member is seeking the services of Behavioral Health, being required to:

1. Wait for the clinic to submit a referral
2. Wait three weeks to be seen by the nearest treatment facility, using that referral...
3. Wait three days to get a referral for an outside provider with an emphasis on timeliness and expedited care - only to be told THAT facility has a three month waiting list does not only discourage seeking treatment at all, but also increases the current condition in regards to anxiety, helplessness, and frustration. If there is not an emphasis on proper mental health care within the community, adverse effects will continue to rise. I am unsure what the proper protocol is or should be but turning someone away roughly three times during this process should be corrected to encourage seeking treatment should be a priority. It does not appear to be here."

Mental health is a critical part of every service member's medical readiness. For example, people suffering from depressive disorders can experience slowed physical reactions, impaired judgment, and indecision, all of which can risk the mission. Additionally, the health and well-being of military families are critical to the readiness of active duty service members. Military families should have access to the same level of quality care afforded to the military members.<sup>42</sup>

## Recommendations, Management Comments, and Our Response

### *Revised Recommendations*

As a result of management comments, we revised three recommendations, including draft recommendation 2.a. to clarify the intent of the recommendation to develop a single MHS-wide staffing approach for the Behavioral Health System of Care; draft recommendation 2.c.5 to specify the DHA Procedural Instruction and TRICARE Policy Manual section applicable to the recommendation; and draft recommendation 2.f.4 to track reasons patients are unable to book an appointment instead of reasons referrals are not used.

<sup>42</sup> Report to Congress on the Department of Defense Plan to Achieve the Vision of the DoD Task Force on Mental Health, September 2007.

### ***Recommendation 1***

**We recommend that the Assistant Secretary of Defense for Health Affairs (ASD[HA]) update the ASD(HA) Memorandum, “TRICARE Policy for Access to Care,” February 23, 2011, to remove the eight-visit limitation for outpatient mental health care.**

#### ***Assistant Secretary of Defense for Health Affairs and Defense Health Agency Comments***

The Defense Health Agency (DHA) Director, responding for the Assistant Secretary of Defense for Health Affairs (ASD[HA]), agreed with the recommendation. The DHA Director stated that the ASD(HA) transferred responsibility for rewriting the policy to the DHA Health Care Operations Directorate, and that the DHA Procedural Instruction is in development, and is expected to be in coordination for approval by March 31, 2021.

#### ***Our Response***

Comments from the DHA Director addressed the specifics of the recommendation. The recommendation is resolved but will remain open. We will close the recommendation once we receive a copy of the updated DHA Procedural Instruction replacing the ASD(HA) Memorandum, “TRICARE Policy for Access to Care,” February 23, 2011, and verify the removal of the eight-visit limitation for outpatient mental health care.

### ***Recommendation 2***

**We recommend that the Defense Health Agency (DHA) Director:**

**2.a. Develop a single Military Health System-wide staffing approach for the Behavioral Health System of Care that estimates the number of appointments and personnel required to meet the enrolled population’s demand for mental health services.**

#### ***Defense Health Agency Director Comments***

The DHA Director agreed with the recommendation and stated that the TRICARE network is currently executing care under a standard staffing model, which will continue in the next generation of TRICARE managed care support contracts. The DHA Director stated that authority over MTFs does not extend to active duty manning models, and that the DHA is in the early of stages of establishing the markets through which the DHA will implement its authority over the MTFs. The estimated date for implementation of this recommendation in the direct care system is no later than September 30, 2024.

### *Our Response*

Although the DHA Director agreed with the recommendation, we disagree with the DHA Director's plan to develop separate and distinct models for direct and purchased care. Therefore, the recommendation remains unresolved. We have modified the recommendation to clarify our intent for the DHA to develop a single MHS-wide staffing approach. The number of appointments and providers required to meet mental health demand for the enrolled population, and a determination of the amount of care to be delivered in direct versus purchased care should be calculated using a single approach.

We request the DHA Director provide additional comments on the final report describing how it will develop and implement a single mental health appointment and staffing approach for the Behavioral Health System of Care. We also request the DHA Director provide a detailed timeline of its plan to implement this approach, including intermediate milestones.

**2.b. Establish policy that identifies which population of beneficiaries by MTF will receive outpatient specialty mental health services through the direct care system.**

### *Defense Health Agency Director Comments*

The DHA Director partially agreed with the recommendation, stating that the DHA Procedural Instruction that replaces DHA Interim Procedures Instruction 18-001 will include basic guidelines that define access based on MTF local capability and capacity. The DHA Director further stated, "DHA recognizes that each MTF is unique in the population served, readiness missions, training requirements, and number of civilian providers available in the community which may all influence the population served. These factors will determine how DHA allocates mental health provider resources across direct care." The DHA Director also stated that, although the DHA is adopting a consistent approach to determining which beneficiaries receive mental health care at an MTF, mental health care will vary by MTF mission and capabilities.

### *Our Response*

Comments from the DHA Director addressed the specifics of the recommendation; therefore, the recommendation is resolved but remains open. Although the DHA Director partially agreed, he also stated that the DHA is adopting a consistent approach to determining which beneficiaries receive mental health care at an MTF, which meets the intent of the recommendation. We will close the recommendation

once the DHA provides evidence that they have defined the population of beneficiaries at each MTF that should expect to receive outpatient mental health care in the direct care system.

**2.c. Update and clarify DoD and Defense Health Agency policy, including TRICARE policy to:**

**2.c.1. Update the access to care standard for a non-urgent initial behavioral health assessment in Defense Health Agency and TRICARE policy to be consistent with the 7-day standard established by ASD(HA) Memorandum, TRICARE Policy for Access to Care, dated February 23, 2011.**

***Defense Health Agency Director Comments***

The DHA Director partially agreed with the recommendation, stating that the direct care system is already aligned with this recommendation as outlined in DHA IPM 18-001. The DHA Director did not agree with the recommendation as it pertains to purchased care. The DHA Director further stated that the “direct care utilizes a 7 day access standard for embedded behavioral health in primary care, but a 28 day access standard for non-urgent initial specialty behavioral health care,” and that embedded behavioral health providers do not exist in most private sector care settings. The DHA Director stated that Federal Regulations and TRICARE policy set access to care standards for specialty mental health care in the private sector at 28 days, consistent with direct care behavioral health clinics.

***Our Response***

The DHA Director partially agreed with the recommendation, but we disagree that the direct care system is already aligned with this recommendation, as well as the DHA’s Director’s statement that there are two different access to care standards for a non-urgent initial behavioral health assessment in the direct care system. We also disagree that the access to care standard for a non-urgent initial behavioral health assessment in the purchased care system is 28 days. Therefore, the recommendation remains unresolved.

In 2007, the Under Secretary of Defense for Personnel and Readiness stated in a Report to Congress, “To facilitate access, we are clarifying policy for both our MTFs and for our TRICARE network providers that limits wait time for initial mental health visits to seven days.”<sup>43</sup> The Assistant Secretary of Defense for Health Affairs Memorandum, “TRICARE Policy for Access to Care,” February 23, 2011, states, “Beneficiaries may choose to receive an initial behavioral health assessment

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<sup>43</sup> Report to Congress on the Department of Defense Plan to Achieve the Vision of the DoD Task Force on Mental Health, September 2007.



from their primary care manager (PCM); an integrated mental health provider within their primary care clinic, if available; or directly from a behavioral health care provider.” It further states that routine care (7-day access to care standard), “also applies to a request for a new behavioral health condition or exacerbation of a previously diagnosed condition for which intervention is required, but is not urgent.” The DHA Interim Procedures Memorandum 18-001, February 4, 2020, also states:<sup>44</sup>

ROUT [routine] appointments may be used for self-referred, non-urgent behavioral health care needs...The MTF will ensure at least three ROUT appointments each duty day are available within 7 days.

The DHA Director’s response to Recommendation 2.c.1. contradicts the 2007 Report to Congress, the 2011 Assistant Secretary of Defense for Health Affairs (ASD[HA]) Policy Memorandum 11-005, and the 2020 DHA Interim Procedures Memorandum 18-001. Those three documents do not limit the 7-day access to care standard for the initial non-urgent mental health assessment to a specific location, such as primary care clinics. The DHA response creates two access to care standards (7 days and 28 days) for the initial non-urgent mental health care assessment based on the location of care, which would contradict previous recommendations, statements, and existing policy. It also creates two access to care standards for the initial non-urgent mental health assessment between the direct care system and the purchased care system. Furthermore, the DHA’s response does not address self-referrals to specialty mental health clinics, which currently have a 7-day access to care standard. Changing the 7-day access to care standard to 28 days may discourage beneficiaries from self-referring to a specialty mental health clinic.

We request that the DHA Director provide comments on the final report confirming that DHA plans to change the access to care standard from 7 to 28 days for beneficiaries who self-refer to a specialty mental health clinic in both the direct and purchased care systems. If the DHA Director plans to change the access to care standard from 7 to 28 days, we request he provide a reason and explanation for the change.

<sup>44</sup> Defense Health Agency Interim Procedures Memorandum 18-001, “Standard Appointing Processes, Procedures, Hours of Operation, Productivity, Performance Measures and Appointment Types in Primary, Specialty, and Behavioral Health Care in Medical Treatment Facilities (MTFs),” February 4, 2020.

**2.c.2. Develop a standard definition and required elements for an initial non-urgent mental health assessment and develop a way to track whether the assessment is completed within the 7-day standard, in either a primary care or a specialty mental health clinic.**

### ***Defense Health Agency Director Comments***

The DHA Director partially agreed with the recommendation and agreed to develop a standard definition of an initial non-urgent mental health appointment. The definition will be distributed via policy and the Behavioral Health Clinical Community channels and will be reflected in the DHA Procedural Instruction that will replace the ASD(HA) Policy Memorandum 11-005, "TRICARE Policy for Access to Care," February 23, 2011. The estimated date of completion is March 31, 2021. However, the DHA did not agree to define the required elements of a non-urgent initial mental health assessment, stating that clinical judgment and patient presentation will dictate which elements are required. The DHA Director agreed to track whether the initial non-urgent assessment was completed, but stated that the DHA plans to use the 7-day access to care standard for care provided in primary care by an embedded behavioral health provider and the 28-day access to care standard for specialty behavioral health.

### ***Our Response***

Although the DHA Director partially agreed with the recommendation and provided a plan and estimated completion date to develop a standard definition, we disagree with implementing and tracking two access to care standards (7 days and 28 days) for the initial non-urgent mental health care assessment based on the location of care. Therefore, the recommendation is unresolved.

As stated in our response to 2.c.1, the DHA Director's response to this recommendation contradicts the 2007 Report to Congress, the 2011 Assistant Secretary of Defense for Health Affairs (ASD[HA]) Policy Memorandum 11-005, and the 2020 Defense Health Agency Interim Procedures Memorandum 18-001. Those three documents do not limit the 7-day access to care standard for the initial non-urgent mental health assessment to a specific location, such as primary care clinics. Additionally, the DHA Director's response did not indicate which TRICARE policy will be updated to define an initial non-urgent mental health assessment and whether the DHA intends to track the completion of the assessment in the purchased care system.

We request that the DHA Director provide comments on the final report and identify which TRICARE policy will be updated to include the definition of an initial non-urgent mental health assessment. We also request the DHA Director provide a plan and estimated completion date for developing a way to track whether the assessment is completed within the access to care standard.

**2.c.3. Describe standard procedures for implementing centralized appointing for behavioral health services.**

***Defense Health Agency Director Comments***

The DHA Director agreed with the recommendation, stating that the basic building blocks for this recommendation are already found in DHA Interim Procedures Memorandum (DHA IPM) 18-001. The DHA Director said that as DHA IPM 18-001 evolves into the DHA Procedural Instruction, it will include greater details, and that the DHA Procedural Instruction will specify requirements for central appointing and templating to reduce variance, optimize capacity, and enhance patient experience. The DHA Director estimates the DHA Procedural Instruction replacing the DHA IPM 18-001 will be in coordination for approval by December 31, 2020.

***Our Response***

Comments from the DHA Director addressed the specifics of the recommendation; therefore, the recommendation is resolved but remains open. We will close this recommendation when the DHA Director provides a copy of the DHA Procedural Instruction that will replace the DHA IPM 18-001, and we verify that the procedures for centralized appointing of behavioral health services are consistent throughout the policy.

**2.c.4. Standardize the outpatient mental health care process of providing behavioral health services from first patient contact through follow-up care for a patient needing non-urgent outpatient mental health care.**

***Defense Health Agency Director Comments***

The DHA Director agreed with the recommendation and stated that the basic processes for making a first appointment in either integrated primary care behavioral health or specialty behavioral health appointments will be codified in a DHA Procedural Instruction that will replace DHA IPM 18-001. The DHA Director said that follow-up appointments will be made in the clinic or by calling central appointments. The DHA Director also stated that, although the process of arranging follow-up care will be standardized to the greatest degree possible, the care itself will vary based upon the provider's clinical judgment and the patient's presentation.

### ***Our Response***

The DHA Director agreed with the recommendation and addressed the specifics of the recommendation; therefore, the recommendation is resolved, but remains open. We request the DHA Director provide a copy of the updated DHA Procedural Instruction that will replace the DHA IPM 18-001 and the updated TRICARE policy standardizing the outpatient mental health care process of providing behavioral health services from first patient contact through follow-up care.

**2.c.5. Align the Defense Health Agency and TRICARE requirements for outcomes monitoring using standardized measurement tools and assessment intervals. Specifically, update the TRICARE Policy Manual (Psychotherapy) to be consistent with the DHA Procedural Instruction 6490.02.<sup>45</sup>**

### ***Defense Health Agency Director Comments***

The DHA Director agreed with the recommendation and identified two nationally recognized outcomes for mental health, published by the National Committee for Quality Assurance: (1) follow-up with a provider within 7 days of discharge from a psychiatric inpatient facility and (2) following patients prescribed anti-depressant medications. The DHA stated that the direct care system monitors both outcomes but that the network system currently only monitors the 7-day follow-up post psychiatric inpatient discharge. The DHA stated that the network system will include and publicly report the anti-depressant monitoring data in the next TRICARE managed care support contracts, which are scheduled to begin in 2023.

### ***Our Response***

Although the DHA Director agreed with the recommendation and proposed corrective actions, the DHA Director did not address the inconsistencies between the DHA Procedural Instruction 6490.02 and the TRICARE Policy Manual (Psychotherapy) as they relate to the time of the initial assessment and the frequency of follow-up assessments for outcomes measurement. Therefore, we have modified the recommendation to be more specific and the recommendation remains unresolved.

The TRICARE Policy Manual (Psychotherapy) only requires measurement in purchased care at baseline, at 60 to 120-day intervals, and at discharge, for PTSD and MDD. The DHA Procedural Instruction 6490.02, however, requires outcome measurement in behavioral health specialty care clinics at baseline and no less

<sup>45</sup> TRICARE Policy Manual 6010.60-M, April 1, 2015, Chapter 7, Section 3.11, Psychotherapy Issue Date: December 5, 1984, Revision: C-13, November 15, 2017. DHA-PI 6490.02 Behavioral Health (BH) Treatment and Outcomes Monitoring, July 12, 2018.

frequently than every 30 days for PTSD and MDD. Furthermore, the DHA Director did not address the inconsistencies between required outcomes measurement intervals in Enclosure 3, Procedures, section 2b and section 6 of DHA Procedural Instruction 6490.02, as discussed in the report.

We request that the DHA Director provide comments to the final report, including a plan and an estimated completion date for correcting inconsistencies in DHA Procedural Instruction 6490.02. Additionally, we request that the DHA Director provide a plan for aligning the outcome measurement requirements in the TRICARE Policy Manual (Psychotherapy) with the DHA Procedural Instruction 6490.02.

**2.d. We recommend that the Defense Health Agency Director develop a method for the Military Health System to book patient appointments in the purchased care system to confirm that patients are able to obtain care, except when a patient chooses to book directly with a purchased care provider.**

### ***Defense Health Agency Director Comments***

The DHA Director agreed with the recommendation and stated that the DHA is developing and implementing a pilot project where beneficiaries will call MHS schedulers, who will perform a “warm hand-off” to private sector mental health providers and confirm availability of the service within access to care standards with the private sector provider. However, the DHA Director stated that the scheduling process in the pilot will be for those with a mental health specialty referral only. The DHA plans to make this service voluntary, so that a self-referred patient has the option of using the appointing center to schedule a mental health appointment, but that the individual is not required to do so.

### ***Our Response***

Comments from the DHA Director addressed the specifics of the recommendation, therefore, the recommendation is resolved, but remains open. We request that the DHA Director provide a plan for full implementation at the end of the pilot. We will close this recommendation when the Military Health System is able to book patient appointments in the purchased care system. Implementing this recommendation will enable the Military Health System to monitor and track those patients who are unable to obtain an outpatient mental health appointment due to the lack of TRICARE civilian provider availability.

**2.e. We recommend the Defense Health Agency Director include TRICARE provider appointment availability for TRICARE beneficiaries within the network adequacy report.**

### ***Defense Health Agency Director Comments***

The DHA Director agreed with the recommendation. The DHA Director stated that the next TRICARE managed care support contracts, scheduled to start health care delivery in 2023, will be updated to require an appointment availability report.

### ***Our Response***

Comments from the DHA Director addressed the specifics of the recommendation, therefore, the recommendation is resolved, but remains open. We request that the DHA Director provide a copy of the draft language of the next TRICARE managed care support contract requirements. We will close this recommendation when the DHA Director provides a copy of the final TRICARE managed care support contract that includes a requirement to provide a report indicating TRICARE provider appointment availability for TRICARE beneficiaries.

**2.f. Develop standardized mental health access to care measures for direct and purchased care for both active duty service members and their families, to include tracking:**

**2.f.1. The time from patient request or referral for mental health care to the time of the initial non-urgent mental health assessment.**

### ***Defense Health Agency Director Comments***

The DHA Director agreed with the recommendation and stated that the direct care system tracks the time from a referral to an appointment but excludes self-referrals from data tracking due to data collection limitations and patient privacy concerns. The DHA Director said that they will continue this tracking policy for the direct care system. For private sector care, the DHA Director stated that the DHA will measure the time from referral to first appointment, which will match the direct care measure of referral to appointment.

### ***Our Response***

Although the DHA Director agreed with the recommendation to measure the time from a referral to the time of the initial mental health assessment and proposed corrective action, he stated that patients who self-refer are excluded from the measurement; therefore, the recommendation is unresolved. As stated in the report, the DHA is not monitoring access to care for patients who choose to self-refer in either the direct or purchased care systems; therefore the DHA is

unable to determine whether it meets the 7-day access to care standard for these patients. Additionally, the DHA Director did not provide an estimated completion date for aligning the purchased care referral to appointment measure with the same measure in direct care.

We request that the DHA Director provide comments on the final report and provide a plan and estimated completion date for developing standardized mental health access to care measures for direct and purchased care. This plan must track the time from patient request for mental health care to the time of the initial non-urgent mental health assessment to monitor access to care for those patients who choose to self-refer for mental health care.

#### **2.f.2. Adherence with outcomes monitoring using standardized measurement tools and assessment intervals.**

##### ***Defense Health Agency Director Comments***

The DHA Director agreed with the recommendation and stated that the Behavioral Health Data Portal is the patient reported outcome tool within the direct care system and it is required to be administered to every behavioral health adult patient every 30 days to monitor care. In private sector care, standardized outcomes measures are currently required for depression, generalized anxiety disorder, and post-traumatic stress disorder. The DHA Director stated that the timing of these outcome measures will be standardized to every 60 days in the next generation of TRICARE managed care support contracts, and that aggregated data by provider will be publicly reported.

##### ***Our Response***

Although the DHA Director agreed with the recommendation to track adherence with outcomes monitoring using standardized measurement tools and assessment intervals, his response establishes two different assessment interval standards for outcomes measurement in the direct and purchased care systems; therefore, the recommendation is unresolved. The DHA Director's response states that the Behavioral Health Data Portal is the direct care system's outcome tool and is administered every 30 days. However, the DHA Director states that the timing in purchased care will be standardized in the next generation of TRICARE managed care support contracts to every 60 days.

We request that the DHA Director provide comments on the final report to confirm and provide rationale for the plan to establish two different assessment interval standards for outcomes measurement between the direct and purchased care systems.



**2.f.3. The number and percentage of mental health referrals that are not used.*****Defense Health Agency Director Comments***

The DHA Director agreed with the recommendation, agreeing to pull referral data and to link it to claims data annually. The DHA Director stated that the DHA will exclude self-referral data tracking due to data limitations and the risk of stigma if self-referrals are tracked.

***Our Response***

The DHA Director agreed with the recommendation and proposed corrective actions; therefore, the recommendation is resolved, but remains open. The DHA Director agreed to pull the data annually, although the current purchased care system reports showing the number and percentage of mental health referrals that are not used are already available monthly. We request that the DHA Director provide an estimated completion date for this recommendation. We will close this recommendation when we receive a copy of the direct and purchased care measures that track the number and percentage of mental health referrals that are not used.

**2.f.4. Reasons patients are unable to book an appointment.*****Defense Health Agency Director Comments***

The DHA Director did not agree with the recommendation. The DHA Director stated that, if a specialty referral is clinically urgent in the judgment of the provider, the current standard process is for 100 percent of these urgent referrals to be appointed by provider-to-provider action within 24 hours to ensure care is delivered. He stated that all other referrals are routine and considered elective, and the decision to choose to seek care is the patient's choice. Therefore, the DHA will not assess non-urgent referrals due to patient privacy, patient autonomy, and preservation of the trust between the patient and the healthcare system. The DHA Director stated that patients have the right to seek or deny care at any point and are able to make that decision privately without intrusion by the system.

***Our Response***

Based on the DHA Director's comments and to further improve access to care we modified this recommendation from tracking the reasons referrals are not used to reasons patients are unable to book an appointment. Therefore, the recommendation remains unresolved. Once the DHA develops and implements a method for the MHS to book patient appointments in the purchased care system (recommendation 2.d), the MHS will be able to document and track whether

patients, who call MHS schedulers to make an appointment are able to obtain care within access to care standards. If the patient is unable to make an appointment the DHA can document and track the reason why, such as the provider is unavailable, the provider is no longer accepting TRICARE patients, or the provider has no available appointments within access to care standards. We request that the DHA Director provide a plan and estimated completion date for developing standardized mental health access to care measures to track the reasons patients are unable to book an appointment in both the direct and purchased care systems.

## Appendix A

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### Scope and Methodology

We conducted this evaluation from July 2019 to June 2020 in accordance with the "Quality Standards for Inspection and Evaluation," published in January 2012 by the Council of Inspectors General on Integrity and Efficiency. Those standards require that we adequately plan the evaluation to ensure that objectives are met and that we perform the evaluation to obtain sufficient, competent, and relevant evidence to support the findings, conclusions, and recommendations. We believe that the evidence obtained was sufficient, competent, and relevant to lead a reasonable person to sustain the findings, conclusions, and recommendations.

This evaluation focused on access to outpatient mental health care for active duty service members and their families delivered by the military health system in direct and purchased care. The military health system provides medical care to active duty service members and their families, retired service members and their families, and others. This evaluation focused on active duty service members and their families because of the DoD's main efforts to support the warfighters and their families and because active duty service members and their families enrolled in TRICARE Prime receive priority over retirees when seeking care at an MTF.

To evaluate our objectives, we reviewed the following public laws; DoD, DHA, and TRICARE policies; and reports to Congress related to mental health access to care:

- Defense Health Agency Procedural Instruction (DHA-PI) 6490.02, Behavioral Health (BH) Treatment and Outcomes Monitoring, July 12, 2018
- Defense Health Agency Procedures Manual Number 6025.13, Volume 1, Clinical Quality Management in the Military Health System, Volume 1: General Clinical Quality Management, August 29, 2019
- Defense Health Agency-Interim Procedures Memorandum (DHA IPM) 18-001, Standard Appointing Processes, Procedures, Hours of Operation, Productivity, Performance Measures and Appointment Types in Primary, Specialty, and Behavioral Health Care in Medical Treatment Facilities (MTFs), July 3, 2018; July 12, 2019; and February 4, 2020
- Health Affairs Policy 11-005, TRICARE Policy for Access to Care, February 23, 2011
- Public Law 114-328, National Defense Authorization Act Fiscal Year 2017, December 23, 2016
- Public Law S.1790 256-260, National Defense Authorization Act Fiscal Year 2020, Section 718 (a), 720 and 722, January 3, 2019

- Report to Congress “Department of Defense Plan to Achieve the Vision of the DoD Task Force on Mental Health,” September 2007
- Report to Congressional Armed Services Committees, House Report 115-676, Pages 132-133 to Accompany H.R. 5515, the National Defense Authorization Act for Fiscal Year 2019, Mental Health Care in the Military Health System, May 24, 2019
- Title 32, Code of Federal Regulations, Section 199.17 (5)(ii), July 1, 2019
- TRICARE Operations Manual 6010.59-M, April 1, 2015. Chapter 2, Section 3.1.1, Revision: C-6, October 20, 2017
- TRICARE Policy Manual 6010.60-M, April 1, 2015, Chapter 1, Section 7.1 Primary Care Manager, Issue Date: May 15, 1996, Revision: C-25, June 15, 2018
- TRICARE Policy Manual 6010.60-M, April 1, 2015, Chapter 7, Section 3.8 Treatment of Mental Disorders – General, Issue Date: December 5, 1984, Revision: C-46, April 30, 2019
- TRICARE Policy Manual 6010.60-M, April 1, 2015, Chapter 7, Section 3.11, Psychotherapy Issue Date: December 5, 1984, Revision: C-13, November 15, 2017

We performed site visits and conducted interviews at the following Headquarters Commands:

- Assistant Secretary of Defense for Health Affairs, Defense Health Headquarters, Falls Church, Virginia
- Defense Health Agency, Defense Health Headquarters, Falls Church, Virginia
- U.S. Army Medical Command, Defense Health Headquarters, Falls Church, Virginia
- U.S. Navy Bureau of Medicine and Surgery, Defense Health Headquarters, Falls Church, Virginia
- National Capital Region Medical Directorate, Walter Reed National Military Medical Center, Bethesda, Maryland
- Tidewater eMSM, Naval Medical Center Portsmouth, Portsmouth, Virginia
- Puget Sound eMSM, Joint Base Lewis McChord, Washington
- National Capital Region Medical Directorate eMSM, Walter Reed National Military Medical Center, Bethesda, Maryland

We visited 13 military installations to assess the access to outpatient mental health care services for active duty service members and their families in both the direct and purchased care settings. We non-statistically selected MTFs based on the parameters and criteria defined in Table 4.

Table 4. MTF Site Selection Table

Parameter	Definition (values)	Criteria for site selection
Size of Parent MTF Active Duty and Active Duty family member enrolled population	SMALL – Less than 60th percentile (0 to 13,000 enrollees) MEDIUM – 60th-90th percentile (13,001-40,000 enrollees) LARGE – greater than 90th percentile (40,000+ enrollees)	Select, at minimum: 2 Large MTFs 2 Medium MTFs 1 Small MTF
Authority, Direction, and Control (ADC) of MTF transferred to DHA on October 1, 2018	No – ADC did not transfer to DHA on October 1, 2018 Yes – ADC did transfer to DHA on 1 October 1, 2018	Select, at minimum: 1 MTF with value of “Yes”
Military Service	DHA (in the National Capitol Region), Air Force, Army, Navy	Select, at minimum: 2 MTFs from each Service 1 MTF in the National Capitol Region managed by DHA
Population prevalence of mental health conditions	No – MTFs in 0- 75th percentile prevalence Yes – MTFs in 75th-100th percentile prevalence	A majority of sites with a value of “Yes”
Use of MHS GENESIS as Electronic Health Record	No – MTF does not use MHS GENESIS in June 2019 Yes – MTF does use MHS GENESIS in June 2019	Select, at minimum: 1 MTF with a value of “Yes”
Location of MTF within enhanced multi-service market	No – Parent MTF not located in enhanced multi-service market Yes – Parent MTF located in enhanced multi-service market	Select, at minimum: 2 MTFs with a value of “Yes” (located in different multi-service-markets)
Location of MTF on Marine base	No – Parent MTF not located on Marine base Yes – Parent MTF located on Marine base	Select, at minimum: 1 MTF with value of “Yes”
TRICARE Supporting network for the MTF in East or West	East – MTF TRICARE Supporting Network is managed by Humana West – MTF TRICARE supporting network is managed by HealthNet	Select, at minimum: 30 percent of MTFs in “East” 30 percent of MTFs in “West”

Additionally, we requested recommendations from stakeholders as to which MTFs we should visit. The U.S. Army Medical Command recommended we visit Kimbrough Ambulatory Care Center. Based on the criteria listed in Table 4 and the recommendation from the U.S. Army Medical Command, we selected the following 13 locations to perform site visits and personnel interviews.

- Irwin Army Community Hospital, Fort Riley, Kansas
- Kimbrough Ambulatory Care Center, Fort Meade, Maryland
- McDonald Army Health Center, Joint Base Langley-Eustis, Virginia
- Madigan Army Medical Center, Joint Base Lewis-McChord, Washington
- McConnell Air Force Base Medical Clinic, McConnell Air Force Base, Kansas
- Malcolm Grow Medical Clinic and Surgery Center, Joint Base Andrews, Maryland
- Langley Air Force Base Hospital, Joint Base Langley-Eustis, Virginia
- Naval Medical Center Camp Lejeune, Camp Lejeune, North Carolina
- Naval Medical Center Portsmouth, Portsmouth, Virginia
- Naval Hospital Bremerton, Bremerton, Washington
- Naval Health Clinic Oak Harbor, Oak Harbor, Washington
- Walter Reed National Military Medical Center, Bethesda, Maryland
- Womack Army Medical Center, Fort Bragg, North Carolina

We evaluated 13 MTFs (direct care system) and their supporting TRICARE networks (purchased care system) to evaluate mental health access to care. We collected testimonial evidence from MTF command leadership, mental health, business operations, and referral management staff. We reviewed appointment booking, referral, and patient satisfaction data from the TRICARE Operations Center, the Joint Outpatient Experience Survey, and the TRICARE East and West managed care support contractors for the months of December 2018 through June 2019. Appendix B provides a detailed analysis of the specialty mental health access to care measures in the direct and purchased care systems from December 2018 to June 2019.

During our interviews, we determined that the three Services and the Defense Health Agency use the terms Mental Health, Behavioral Health, and Psychological Health interchangeably. The Army and the DHA prefer the term Behavioral Health, the Air Force prefers the term Mental Health, and the Navy prefers the term Psychological Health. Although the Army and the DHA prefer Behavioral Health because it is generally seen as a broader category, representatives from

the Navy Bureau of Medicine and Surgery stated that psychological health is more encompassing. For this report, the term mental health is used, unless we are referencing a policy that uses another term.

## Use of Computer-Processed Data

We used computer-processed data to perform this evaluation. Specifically, we used appointment booking, referral, and patient satisfaction data for mental health from the TRICARE Operations Center, the Joint Outpatient Experience Survey, and the TRICARE Managed Care Support Contractors.

For the purchased care system, we used data from the Access Standards Report, which is part of the TRICARE East and West managed care support contractors' contract data requirements list that were provided to DHA. To assess the reliability of the data, we reviewed the appointment booking and referral data and methodology documents from the TRICARE Operations Center and the referral data in the TRICARE Access Standards Report. According to specialty access to care methodology documents and MTF staff, there were no system-generated standardized access to care reports available in general for the reporting period of December 2018 to June 2019 for MTFs that have transitioned to the new electronic health record, MHS GENESIS, in the direct care system.

We determined the specialty access to care reports in both the direct and purchased care systems included only those patients who were able to obtain an appointment, excluded patients who self-referred, and considered only the patients' first appointment. Therefore, we recognized there were moderate data limitations in how the MHS measures access to mental health care because the data does not include all of the patients who attempted, but were unable, to book a mental health appointment, which is discussed in the report. However, we found the data were sufficiently reliable for evaluating access to mental health care for those patients who received an appointment. Although we used the specialty access to care reports in the direct and purchased care systems to support our finding that the DoD is not meeting mental health access to care standards, we also used other evidence to support our finding. We obtained corroborating testimonial and documentary evidence to support the finding that the DoD is not meeting mental health access to care standards. We have testimonial evidence from MTF staff as well as MTF-level reports from the individual site visits showing that some MTFs are not meeting mental health access to care standards.



## Prior Coverage

During the last 5 years, the Government Accountability Office (GAO) and the DoD Office of Inspector General (DoD OIG) issued four reports discussing mental health and access to care.

Unrestricted GAO reports can be accessed at <http://www.gao.gov>. Unrestricted DoD OIG reports can be accessed at <http://www.dodig.mil/reports.html/>.

### GAO

GAO-20-371, "Defense Health Care: Additional Information and Monitoring Needed to Better Position DoD for Restructuring Medical Treatment Facilities," May 2020

The FY2017 NDAA included a provision for the GAO to review the DoD's plan to restructure MTFs. This report addressed the extent to which 1) the plan's methodology prioritized statutory elements and considered complete information, and 2) the DoD is positioned to execute MTF restructuring transitions. The GAO reviewed the DoD's plan, MTF workload and cost data, and interviewed DoD leaders and officials at 11 MTFs. The GAO found the civilian health care assessments did not consistently account for provider quality or access to an accurate and adequate number of providers near MTFs, and cost-effectiveness assessments were based on a single set of assumptions. The GAO also found that the DoD conducted limited assessments of MTFs' support to the readiness of military primary care and non-physician medical providers—an issue DoD officials stated they will address during MTF transitions. The GAO made six recommendations, including that future MTF assessments use more complete and accurate information about civilian health care quality, access, and cost-effectiveness; and that the DoD establish roles, responsibilities, and progress thresholds for MTF transitions.

GAO-19-488, "DoD Health Care: Improvements Needed for Tracking Coordination of Specialty Care Referrals for TRICARE Prime Beneficiaries," June 2019

This report identified the need for improvements in the tracking and the coordination of specialty care referrals for TRICARE Prime Beneficiaries. The objective of the report examines the extent to which the referral management process facilitates the coordination of primary and specialty care for TRICARE Prime beneficiaries. The GAO found that MTFs using MHS Genesis were not adequately trained on how to use the referral management component which limited the MTFs' ability to process and track referrals. The GAO recommend that staff are trained to process and accurately document information about specialty care referrals.

GAO-18-361, "Defense Health Care: TRICARE Surveys Indicate Nonenrolled Beneficiaries' Access to Care Has Generally Improved," March 2018

The GAO was directed by the FY 2008 NDAA to review the surveys of nonenrolled beneficiaries and civilian providers about access to care under the TRICARE Standard and Extra options. Additionally, the FY 2017 NDAA included a provision for the GAO to review access to care under TRICARE Extra. This report addressed both provisions. The GAO stated, "Nationwide, we found an overall decrease reported in civilian providers' acceptance of new TRICARE patients in the 2012-2015 civilian provider survey (55 percent) compared to the 2008-2011 civilian provider survey (58 percent). However, when we analyzed acceptance by provider type, we found that the overall decrease was mainly attributable to a decrease in mental health care providers' acceptance rates, as primary and specialty care providers' acceptance rates remained unchanged. Specifically, mental health care providers' TRICARE acceptance rate decreased from 39 to 36 percent."

GAO-16-416, "Defense Health Care: DOD Is Meeting Most Mental Health Care Access Standards, but It Needs a Standard for Follow-up Appointments," April 2016

The DoD reported that between 2005 and 2013, the number of individuals who received mental health care through the DoD's MHS grew by 32 percent. The National Defense Authorization Act for FY 2015 contains a provision for the GAO to assess the availability and accessibility of mental health care in the DoD's MHS for military service members. This report examined 1) the mental health care the DoD makes available to service members domestically and overseas, and 2) the accessibility of mental health care provided to service members domestically and overseas. The GAO analyzed recent, available data on MHS mental health utilization, staffing, and appointment access and compared access data to relevant DoD standards. The GAO reviewed mental health data from several DoD surveys as well as documents related to MHS mental health care. The GAO also interviewed DoD and Service officials and representatives from service member and provider associations. The GAO recommended that the DoD establish an access standard for mental health follow-up appointments and regularly monitor data on these appointments.

**DoD OIG**

DoDIG-2018-111, "Access to Care at Selected Military Treatment Facilities," May 1, 2018

The report determined that the DoD did not consistently meet the access to care standards for urgent and routine appointments at selected MTFs. Three of the seven MTFs met access to care standards for routine and urgent appointments. The report recommended that the DHA Director establish a standard method across the Military Departments for calculating the number of patients assigned to each provider and establish a standard method for decreasing the number of appointments per provider based on their additional duties. Additionally, the report recommended that the DHA Director convene a working group with personnel from the Military Departments' Surgeons General and the Air Force Personnel Center to conduct a review to determine if position descriptions and pay grades for civilian medical personnel assigned to MTFs were consistent and consider standardizing position descriptions and pay grades across the Military Departments. The report further recommended that the DHA Director, in coordination with the Air Force Surgeon General, develop a plan outlining how the DHA will assume authority, direction, and control over Air Force MTFs to make changes necessary to improve access to care and hold MTF commanders accountable when the MTFs do not meet access to care standards.

## Appendix B

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### Access to Care Measures

In the direct care system, the specialty access to care standard of 28 days is measured from the time the referral is ordered to the date of the MTF appointment.<sup>46</sup> Within the purchased care system, access to specialty mental health care is measured from 3 days after the date the referral is approved to the date the service was provided. The standard for this measure is also 28 days. For the evaluation, we used appointment booking, referral, and patient satisfaction data from the TRICARE Operations Center, the Joint Outpatient Experience Survey, and the TRICARE Managed Care Support Contractors for the months of December 2018 through June 2019. Table 5 represents Tables 1, 2, and 3 in one view to display a comparison of the direct and purchased care systems' ability to meet specialty mental health access to care standards.

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<sup>46</sup> Defense Health Agency Interim Procedures Memorandum 18-001.

Table 5. Mental Health Average Number of Days from Referral Ordered or Approved, plus three days, to Appointment by Ordering Parent MTF (DC / PC BH / PC PSY)<sup>47</sup>

Service	Military Medical Treatment Facility	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Army	Irwin Army Community Hospital	33/34/41	20/46/55	24/43/76	28/34/19	24/43/28	25/50/64*	24/26*/25*
Army	Kimbrough Ambulatory Care Center	31/25/33	29/24/40	31/26/44	32/24/27	30/33/25	29/40/25	27/31/19
Army	McDonald Army Health Center	30/16/36	19/38/24	29/38/44	29/22/30*	23/21/38*	28/25/27*	21/19/40
Army	Madigan Army Medical Center	N/A /39/50	N/A /38/18	N/A /39/46	N/A /38/30	N/A /31/40	N/A /42/34	N/A /52/46
Air Force	McConnell Air Force Base Medical Clinic	45/28/40	28*/35/34	16/16/23*	31*/39/23	12*/26/39	28*/36/18	16*/16/29*
Air Force	Malcolm Grow Medical Clinic and Surgery Center	33/23*/61	36/16/23*	34/20/57	31/21/51	30/15/19	34/39/9	37/21/36*
Air Force	Langley Air Force Base Hospital	30/33/35	22/26/28	35/16/46	21/18/35	25/22/31	28/27/28	22/39/41
Navy	Naval Medical Center Camp Lejeune	26/41/32	20/35/34	21/40/25	23/26/27	21/33/38	20/33/35	21/32/45
Navy	Naval Medical Center Portsmouth	36/27/37	34/28/24	37/29/29	29/37/38	32/29/36	38/32/34	33/25/41
Navy	Naval Hospital Bremerton	N/A /30/56	N/A /38/ N/A	N/A /25/23	N/A /47/90	N/A /33/47	N/A /29/14*	N/A /46/43*
Navy	Naval Health Clinic Oak Harbor	N/A /31/6*	N/A /39/34*	N/A /38/39*	N/A /25/118*	N/A /56/ 56	N/A /33/81*	N/A /57/79*

Footnotes used throughout this Appendix are defined on the final page.

<sup>47</sup> Data Source for Direct Care: TRICARE Operations Center website - <https://info.health.mil/staff/analytics/atcreports/Pages/apptreports.aspx>  
 Data Source for Purchased Care: DoD OIG Generated from the East and West TRICARE Managed Care Support Contractors' Access Standards Report.

*Table 5. Mental Health Average Number of Days from Referral Ordered or Approved, plus three days, to Appointment by Ordering Parent MTF (DC / PC BH / PC PSY) (cont'd)*

Service	Military Medical Treatment Facility	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Defense Health Agency	Walter Reed National Military Medical Center	30/14/43	26/30/79	28/31/55	31/33/49	31/42/58*	31/43/32	32/18/9*
Defense Health Agency	Womack Army Medical Center	22/30/33	19/32/30	21/33/28	23/27/27	23/31/30	22/33/25	21/30/27

\* Indicates there were fewer than five referrals documented for that month.

Green = Both Direct and Purchased Care met the 28 day specialty access to care standard  
 Yellow = Either the Direct or Purchased Care did NOT meet the 28 day specialty access to care standard  
 Red = Both Direct and Purchased Care did NOT meet the 28 day specialty access to care standard

**LEGEND**

- DC** Direct Care Specialty Behavioral Health Clinics
- PC BH** Purchased Care Behavioral Health
- PC PSY** Purchased Care Psychiatry

# Management Comments

## Assistant Secretary of Defense Health Affairs

The Defense Health Agency Director responded on behalf of the Assistant Secretary of Defense for Health Affairs (ASD[HA]) for recommendation 1.

## Defense Health Agency Director



**DEFENSE HEALTH AGENCY**  
7700 ARLINGTON BOULEVARD, SUITE 5101  
FALLS CHURCH, VIRGINIA 22042-5101

June 26, 2020

Joe A. Baker  
Program Director  
Program, Combatant Command and Overseas Contingency Operations  
U.S. Department of Defense Office of Inspector General  
4800 Mark Center Drive  
Alexandria, VA 22350-1500

Dear Mr. Baker:

I am in receipt of the Department of Defense Inspector General's (DoD IG's) Draft Report No. D2019-DEV0PB-0178.000, "Evaluation of Access to Mental Health Care in the Department of Defense." Please see the attached DHA's response to the audit's findings and recommendations.

The Assistant Secretary of Defense for Health Affairs (ASD[HA]) transferred responsibility for Recommendation 1. to the Defense Health Agency (DHA), and DHA concurs and will make this change in an upcoming instruction.

The Defense Health Agency (DHA) concurs with Recommendations 2.A., 2.C. 3 – 5., 2.D., 2.E., and 2.F. 1-3. These focus on developing staffing and measuring access, unused referrals, and outcomes, as well as developing centralized appointing and booking and measuring clinical outcomes. DHA is in the process of implementing these recommendations, though some will not be fully implemented until the next generation of TRICARE contracts take effect.

The DHA partially concurs with Recommendations 2.B. and 2.C.1 -2. These focus on creating a consistent policy regarding which beneficiaries will receive MH services at military treatment facilities (MTF), adopting a 7-day access standard for all MH care, and establishing a consistent definition of a MH assessment. The DHA is adopting a consistent approach to determining which beneficiaries receive MH care at an MTF, but this will vary by MTF mission and capabilities. The 7-day access standard will be applied to embedded MH in primary care clinics, however the 28-day access standard which applies to all specialty care will continue to be applied to BH specialty care clinics in both direct and private sector care. A standard process will be established for MH assessments, but the elements of that assessment will be tailored to each beneficiary's needs.

The DHA nonconcur with Recommendation 2.F.4., tracking the reasons MH referrals are not used as this would require invasive questioning of beneficiaries which could increase stigma and reluctance to seek needed care.



## Defense Health Agency Director (cont'd)

Thank you for the opportunity to review and respond to the draft report recommendations.  
My point of contact for this topic is [REDACTED]

PLACE, RONALD J. Digitally signed by  
JOSEPH [REDACTED] PLACE, RONALD, JOSEPH  
[REDACTED] Date: 2020.06.26 19:18:26 -04'00'

RONALD J. PLACE  
LTG, MC, USA  
Director

Attachment:  
DHA Response to DoD OIG Report D2019-DEV0PB-0178.000

## Defense Health Agency Director (cont'd)

**DEPARTMENT OF DEFENSE INSPECTOR GENERAL DISCUSSION DRAFT  
REPORT UNDATED  
PROJECT NUMBER D2019-DEV0178.000**

**“EVALUATION OF ACCESS TO MENTAL HEALTH CARE IN THE DEPARTMENT  
OF DEFENSE”**

**Department of Defense Comments  
to the Inspector General Recommendations**

**RECOMMENDATION 1: Removal of eight-visit limitation for outpatient mental health care.**

**DoD RESPONSE:** The Defense Health Agency (DHA) concurs with this recommendation. HA has transferred the policy rewrite to the DHA, Health Care Operations Directorate. The DHA- Procedural Instruction (PI) is in development with an estimated date of completion to be in coordination for approval by the end of Q2 in FY2021.

**RECOMMENDATION 2a: MHS-wide staffing model for direct and purchased care.**

**DoD RESPONSE:** DHA concurs with this recommendation. The TRICARE network is currently executing care under a standard staffing model and has also included this in the next generation T-5 TRICARE managed care support contracts. DHA’s authority over Military Treatment Facilities (MTFs) does not extend to active duty manning models. In addition DHA is still early in the process of creating Markets and Market Directors. Therefore the estimated date for implementation of this recommendation in the direct care system is no later than 30 September 2024, which is one year necessary to drive full implementation once transition is complete.

**RECOMMENDATION 2b: Policy that identifies which beneficiaries may receive outpatient mental health services in the MTF.**

**DoD RESPONSE:** DHA partially concurs with this recommendation. The DHA-PI that replaces IPM 18-001 will include basic guidelines, which will define access based on MTF local capability to provide mental health services and capacity or optimized supply of appointments with any available mental health provider. DHA recognizes that each MTF is unique in the population served, readiness missions, training requirements, and number of civilian providers available in the community which may all influence the population served. These factors will determine how DHA allocates mental health provider resources across direct care,.

**RECOMMENDATION 2.c.1: Non-urgent initial behavioral health assessment to meet a 7-day access to care standard.**

**DoD RESPONSE:** DHA partially concurs with this recommendation. The direct care system is already aligned with this recommendation as outlined in DHA IPM 18-001 for mental health providers embedded in primary care. DHA does not concur with this recommendation for private

## Defense Health Agency Director (cont'd)

2

sector care or for direct care specialty behavioral health care clinics. As noted in 2.C.2. below, direct care utilizes a 7 day access standard for embedded behavioral health in primary care, but a 28 day access standard for non-urgent initial specialty behavioral health care. Embedded behavioral health does not exist in most private sector care settings. Private sector care provides specialty behavioral health care. Federal Regulation and TRICARE policy for access to all specialty care in the private sector care network, including mental health is 28 days. This is consistent with direct care behavioral health clinics, and is appropriate for non-urgent care.

**RECOMMENDATION 2.C.2: Standard definition and tracking for initial non-urgent mental health assessment within a 7-day access standard.**

**DoD RESPONSE:** DHA partially concurs with this recommendation using the 7 day access standard for behavioral health embedded in primary care but the 28 day access for specialty behavioral health. DHA concurs with developing a standard definition of an initial non-urgent mental health appointment, which will be included in the DHA-PI that will replace DHA IPM 18-001. This will be distributed via policy and the Behavioral Health Clinical Community channels. This will be reflected in the DHA-PI that will replace HA Memorandum, "TRICARE Policy for Access to Care," dated February 23, 2011. This is under development with an estimated date of completion by the end of Q2 in FY2021. DHA non- concurs with requiring particular elements of a non-urgent initial mental health assessments as clinical judgement and patient presentation will dictate which elements are required.

**RECOMMENDATION 2.C.3: Standard procedures for centralized appointing.**

**DoD RESPONSE:** DHA concurs with this recommendation for direct care. The basic building blocks for this recommendation are already found in DHA IPM 18-001. As the IPM evolved into the DHA-PI it will include greater details. The estimated deadline of completion and for it to be in coordination for approval of the PI to replace the IPM 31 December 2020. The PI will specify requirements for central appointing and templating to reduce variance, optimize capacity and enhance patient experience.

**RECOMMENDATION 2.C.4: Standardized outpatient mental health care process.**

**DoD RESPONSE:** DHA concurs with this recommendation. The basic processes for making a first appointment in either integrated primary care behavioral health or specialty behavioral health appointments will be codified in the PI to replace DHA-IPM 18-001; follow-up appointments will be made in the clinic or by calling central appointments. Although the process of arranging follow-up care will be standardized to the greatest degree possible, the follow-up care itself will vary based upon the provider's clinical judgement and the patient's presentation.

**RECOMMENDATION 2.C.5: DHA and TRICARE outcomes monitoring.**

**DoD RESPONSE:** DHA concurs with this recommendation. The nationally recognized outcomes (National Committee for Quality Assurance) in Mental Health are (1) follow-up with a provider within 7 days of discharge from a psychiatric inpatient and (2) following patients prescribed anti-depressant medications. Currently, the direct care system monitors both

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outcomes. The network system currently monitors the 7 day follow-up post psychiatric inpatient discharge. The network system will include and publicly report the anti-depressant monitoring data in the next TRICARE managed care support contracts which are scheduled to start health care delivery in 2023.

**RECOMMENDATION 2.D.: Method for booking purchased care appointments to confirm that patients are able to obtain care (except when a patient chooses to book directly with a purchased care provider).**

**DoD RESPONSE:** DHA concurs. DHA is currently developing and implementing a pilot in which MHS schedulers will perform warm hand offs of beneficiaries to private sector mental health providers after confirming availability of the required service within access standards at the private provider; however, this process will be for those with a mental health specialty referral only. DHA will make this service voluntary, so that a self-referred patient has the option of using the appointing center to arrange a MH appointment but is not required to do so.

**RECOMMENDATION 2.E.: TRICARE provider appointment availability included in network adequacy report.**

**DoD RESPONSE:** DHA concurs with this recommendation. The next TRICARE managed care support contracts, which is scheduled to start health care delivery in 2023 will be updated to include this type of report.

**RECOMMENDATION 2.F.1.: Standardized mental health access to care measures.**

**DoD RESPONSE:** DHA concurs with this recommendation. The direct care system currently tracks referrals to appointment. DHA excludes self-referrals from data tracking due to data collection limitations and patient privacy and will continue to do so. The goal for direct care is same day disposition of all referrals and next day booking. In private sector care, DHA will utilize time from referral to first appointment. This will match the direct care measure of referral to appointment.

**RECOMMENDATION 2.F.2.: Standardized mental health outcomes monitoring.**

**DoD RESPONSE:** DHA concurs with this recommendation. The Behavioral Health Data Portal is the direct care system web based patient reported outcome tool is required to be administered to every behavioral health adult patient every 30 days to monitor care.

In private sector care, standardized outcomes measures are currently required for depression, generalized anxiety disorder, and post-traumatic stress disorder. The timing of these will be standardized to every 60 days in the next generation of TRICARE contracts and aggregated data by provider will be publicly reported.

**RECOMMENDATION 2.F.3.: Standardized measures for mental health referrals not used.**

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**DoD RESPONSE:** DHA concurs with this recommendation. DHA concurs with pulling referral data and linking to claims data annually; DHA will exclude self-referral data tracking due to data limitations and the risk of stigma if self-referrals are tracked.

**RECOMMENDATION 2.F.4.: Standardized measures for reasons referrals are not used.**

**DoD RESPONSE:** DHA non-concurs with this recommendation. If a specialty referral is clinically urgent in the judgment of the provider, the current standard process is for 100% of these urgent/non-elective referrals to be appointed by provider-to-provider action within 24 hours to ensure care is delivered. All other referrals are routine and considered elective and the decision to choose to seek care is the patient's choice. Therefore, DHA will not assess these referrals due to patient privacy, patient autonomy and preservation of the trust between patient the healthcare system. Patients have the right to seek or deny care at any point. They also have the right to make that decision privately without intrusion by the system.

## Acronyms and Abbreviations

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<b>ASD(HA)</b>	Assistant Secretary Of Defense Health Affairs
<b>DHA</b>	Defense Health Agency
<b>DHA IPM</b>	Defense Health Agency Interim Procedural Memorandum
<b>FY</b>	Fiscal Year
<b>GAO</b>	Government Accountability Office
<b>MDD</b>	Major Depressive Disorder
<b>MHS</b>	Military Health System
<b>MTF</b>	Military Treatment Facility
<b>NDAA</b>	National Defense Authorization Act
<b>OIG</b>	Office Of Inspector General
<b>PHRAMS</b>	Psychological Health Risk Adjusted Model For Staffing
<b>PTSD</b>	Post-Traumatic Stress Disorder





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